MARCH 1, 1950

MODERN MEDICINE

The Journal of Diagnosis and Treatment

Dr. R. A. Gordon
(see page 9)

Table of contents
page 9

The most "persuasive" oral germicide you can prescribe

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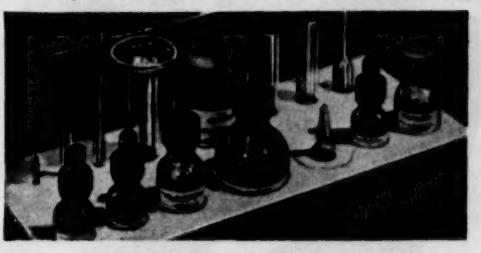

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*U. S. Pat. Applied For.

1. Ricketts, W. A.; Carson, R. M., and Saeks, R. R.: Am. J. Obst. & Gynec. 56:955 (Nov.) 1948.

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References. 1. Finkel, M., Levine, A. J., Wohl, M. Twenty percent dissolved benzocaine ointment in the treatment of burns. Ind. Med. 17: 475 Dec., 1948.
2. Tainter, M. L. Some general considerations in evaluating local anesthetic solutions in patients. Anesthesiology 5: 470 Sept. 1944.
3. Adriani, J. The pharmacology of anesthetic drugs. Chas. C. Thomas, 1941, p. 49.

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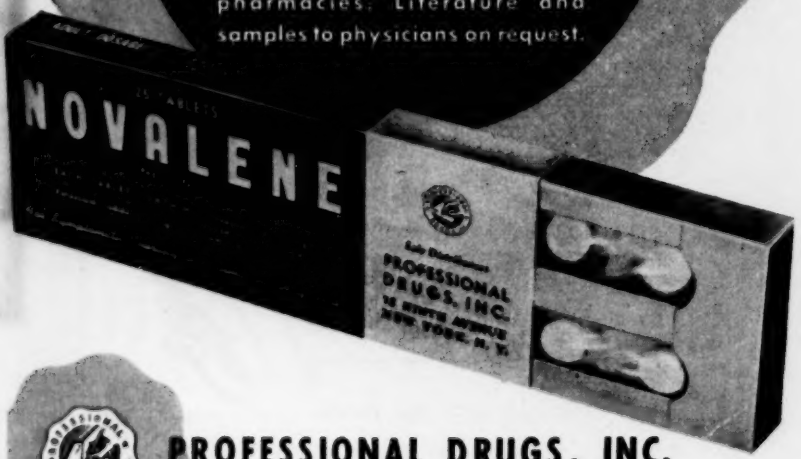

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CORRESPONDENCE 14

FORENSIC MEDICINE 28

QUESTIONS & ANSWERS 38

SPECIAL ARTICLE

Anesthetic Disasters
R. A. Gordon 45

MEDICINE

Aureomycin Therapy of Herpes Zoster
Maxwell Finland, Edmund F. Finnerty, Jr., Harvey S. Collins, John W. Baird, Thomas M. Gocke, and Edward H. Kass 49
Venous Stasis in the Legs
W. J. Merle Scott and Michael Radakovich 50
Guaiac Test for Occult Blood 51
Chilblains
John T. Ingram 52

PEDIATRICS

Diagnosis of Mumps 53
Whooping Cough 53
Brain Tumors in Children
A. Earl Walker and Theron L. Hopple 54
Bacterial Pneumonia 55

GERIATRICS

Hyperthyroidism after Sixty
Elmer C. Bartels and J. W. Kingsley, Jr. 56

GYNECOLOGY & OBSTETRICS

Functional Sterility and Amenorrhea
Rita S. Finkler 57
Causes and Effects of Eclampsia
Charles I. Bryans, Jr., and Richard Torpin 58

Contents for March 1 1950

VOL. 18, NO. 5

THE MAN ON THE COVER is Dr. R. A. Gordon, general secretary of the Canadian Anaesthetists' Society and author of the Special Article, "Anesthetic Disasters," on page 45 of this issue. Dr. Gordon has written many articles relating to the science of anesthesia and his introduction of the intravenous administration of procaine in treatment of burns attracted world-wide attention. During the war he served overseas as anesthetist in the Royal Canadian Army Medical Corps. He still serves as consulting anesthetist to the Toronto Military Hospital, in addition to carrying on an active practice and teaching at the University of Toronto.

Contents for March 1 1950

CONTINUED

SURGERY

A Nonmoving Ligature-Holding Bobbin
John Devine 59

SURGICAL TECHNIGRAM

Hemorrhoidectomy
F. M. Al Akl 60

SURGERY

Blood Pressure and Surgical Position
L. H. Peterson, Kenneth F. Eather, and Robert D. Dripps 64

UROLOGY

Serum Acid Phosphatase 65
Bacillary Urinary Infections 65

MEDICAL FORUM

Abdominal Paracentesis 68
Temperature Cycle in Obstetrics and Gynecology 69
Amyotrophic Lateral Sclerosis 69
Diet in Diabetes 70
Culdoscope in Gynecology 72
What Can Be Done for the Hay Fever Patient? 73

DIAGNOSTIX 74

SHORT REPORTS 80

MEDICAL NEWS

The Accident-prone Automobile Driver
W. A. Tillmann and G. E. Hobbs 100

WASHINGTON LETTER 108

CURRENT BOOKS & PAMPHLETS 118

PATIENTS I HAVE MET 124

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Correspondence

Communications from the readers of MODERN MEDICINE *are always welcome. Address communications to The Editors of* MODERN MEDICINE, *84 South 10th St., Minneapolis 3, Minn.*

Iodized Oil Safer

TO THE EDITORS: I always enjoy looking over *Modern Medicine* and in a recent issue (Jan. 1, 1950, p. 92) I was especially interested in the Diagnostix report of the patient with the spontaneous rupture of the esophagus.

There is one correction that I would like to make in Part IV of the discussion and that is concerning the suggestion that a swallow of barium might be used to aid in diagnosis. Barium should not be given in suspected rupture of the esophagus or in patients having complete or almost complete esophageal obstruction. Iodized oil is just as satisfactory and is much safer.

PORTER P. VINSON, M.D.
Richmond, Va.

Intravenous Route During Shock

TO THE EDITORS: While I was serving in the Army as a surgeon in a station hospital, we developed and used a technic which I would like to pass on to any of my colleagues who may be interested.

In the course of two years we saw many patients who entered our hospital in various stages of primary and secondary shock. As we all know, giving intravenous medications to patients with collapsed venous systems is a problem. The situation requires a "cut-down" on a vein with the insertion of a catheter or some such procedure.

Use of the corpora cavernosa of the penis has been reported, but I do not think this convenient route has been given the recognition it deserves. We used it many times in plasma and blood transfusions, thereby saving much time, which is so vital in all types of shock.

From our experience, the network of the corpora will take blood or plasma as fast as any vein. For intravenous medication the process is even easier, as a smaller needle may be used. This route was also used with success in male infants who needed transfusions and was much simpler than trying to employ head veins. In all of our cases we had no infections or sequelae of any kind except, perhaps, a mild disapproval of the nursing staff.

The penis may be prepared and made as sterile as possible by any convenient method. We used tincture of green soap and followed up with merthiolate. The head of the penis is grasped and the penis extended.

For transfusions, we used a 1-in., No. 20 needle, inserting it toward the symphysis pubis at about the midpenis position. A tough fibrous

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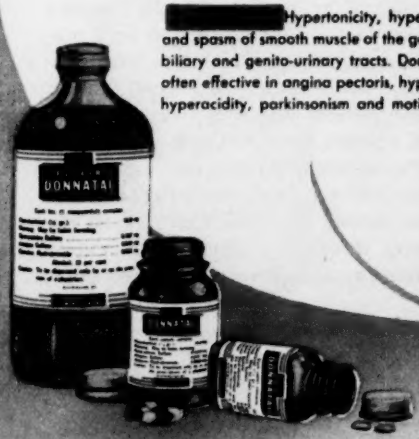
Elixir: Infants: ½ teaspoonful 2 or 3 times daily, as necessary. Children: 1 teaspoonful, 2 or 3 times daily, as needed. Adults: 1 or 2 teaspoonfuls, 3 or 4 times daily.

[redacted]1. Goodman, L. and Gilman, A.: The Pharmacologic Basis of Therapeutics, The Macmillan Co., New York, 1941. 2. Kilstein, S. L.: Rev. Gastroenterol., 14:171, 1947. 3. Lee, L. W.: Nebraska State Med. J., 34:59, 1949. 4. Morrissey, J. B.: J. Urol., 57:635, 1947. 5. Ricci, J. V.: Contributions from Dept. of Gynecology, City Hospital, New York, 1946, New York Medical College, New York, 1947. 6. Stephens, G. K.: J. Oklahoma St. Med. Assn., 42:246, 1949.



TABLETS • CAPSULES • ELIXIR

sheath surrounds each corpora so that some pressure is necessary before entering. When the corpora is entered, blood returns in the syringe or tubing as in any intravenous puncture. The needle and tube are strapped first to the end of the penis and then to the abdomen or leg.

In most cases no anesthesia was required, but we did abolish most of the pain when necessary with a small amount of 2% procaine just under the skin.

In infants a smaller gauge needle was used and the injection made with a syringe with a three-way stopcock, just as is used in regular head vein sets.

M. D. BENTLEY, M.D.
Sebewaing, Mich.

Exercise Reprints Available

TO THE EDITORS: Would you kindly send me a reprint of "Postpartum Exercises" by Lt. Willie Rebecca Harvey, WMSC, which appeared in your August 15, 1949 issue.

H. B. WOOLLEY, M.D.
Idaho Falls, Idaho

¶ Because of the demand, a new supply of reprints of "Postpartum Exercises" has been ordered. A limited number are available again.—Ed.

Reserves Copy of Index

TO THE EDITORS: I am one of the fortunate ones who regularly receive your journal. I am delighted to learn that a *Modern Medicine Index* of 1949 is being published. Would you please reserve a copy for me. Thank you for your wonderful service.

MORRIS FRANKLYN H. LEVY, M.D.
Brooklyn

Good Results with Blastomycosis

TO THE EDITORS: I have just read Dr. David T. Smith's nice article on immunologic types of blastomycosis (*Modern Medicine*, Jan. 1, 1950, p. 53).

During my absence several years ago, my locum tenens was treating with potassium iodide a patient who had a severe case of blastomycosis. The patient was fast getting worse. When I returned I suggested that we give him antimony and potassium tartrate intravenously. We did so, giving him 3/8 gr. for the first dose and 3/4 gr. thereafter three times weekly. Then, after 6 doses, we gave him 1 1/2 gr. in the same routine. In about a month he was practically well, and in six weeks was completely recovered.

I have been impatiently waiting for another case. None have shown up in my practice. So far as I know, this treatment is original with me, and I am very anxious to have some of my fellow colleagues try it. The results, of course, may be just a "flash in the pan," so be patient with the suggestion.

Last month, I suggested antimony and potassium tartrate in the treatment of a suspicious inflammatory mass in the lung diagnosed as a possible malignancy or as an inflammatory tumor the size of a small orange. The patient also had a severe cough of a year's duration with profuse expectoration of muco-pus containing streptococci and staphylococci but no tumor cells. We fluoroscoped the lung three days ago. Cough, expectoration, and tumor are entirely gone.

F. A. ALLIN, M.D.
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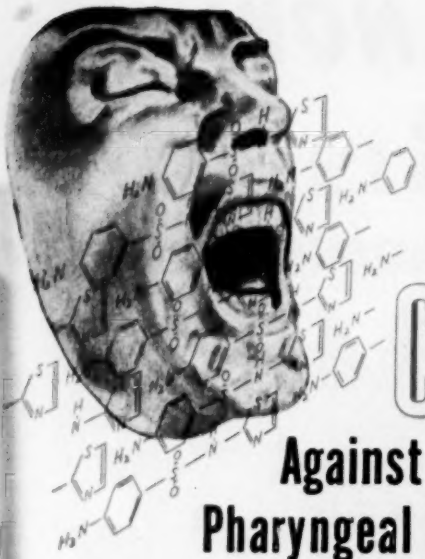

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*Neiman, I. S.: Prophylactic Value of Sulfathiazole, Archives of Otolaryn. *47*:158-164 (Feb.) 1948.

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Long-sought Information

TO THE EDITORS: I will be ever so grateful to you if you could provide the address and apply it to the enclosed envelope for Dr. Charles G. Hutter, whose article on the bee cell pessary recently appeared in *Modern Medicine* (Jan. 1, 1950, p. 68).

Several years ago I inherited several of these pessaries from a preceptor. When my supply was gone I attempted to replenish it, but exhaustive inquiries produced no pessaries, only the information that the device had been manufactured in Germany and that none had been imported since before the last war and that no more would be available. You can imagine then what a very pleasant surprise it was to encounter the bee cell pessary in your magazine.

I have received *Modern Medicine* almost since its inception and have found a pleasant surprise in practically every issue. My thanks for your very modern *Modern Medicine.*

JOHN L. LANGOHR, M.D.
Columbia City, Ind.

¶Dr. Hutter says that the pessary he described was ordered from the Bee Cell Company, Box 212, Buffalo 5, N.Y.—Ed.

Quantity Just Right

TO THE EDITORS: I first contacted your journal when I came to this country for my internship. Since then, I have come to like and appreciate more and more your very excellent medical digest. I would like to congratulate you on the fine quality and just right quantity of all these reports.

ROBERT GEIGER, M.D.
New York City

Questions Value of Prenatal Care

TO THE EDITORS: Before the advent of prenatal care, most women bore children without needing any stitches for repair.

After elaborate prenatal care, modern obstetricians expect major tears as a rule and routinely do episiotomies which require several sutures for repair.

Calcium with calcium-stabilizing factors, administered during normal pregnancy, prevents the physiologic softening of the maternal pelvis and causes the premature calcification and hardening of the fetal bones in general and of the fetal skull in particular.

ALFRED ROSSKAMM ROSS, M.D.
New York City

Alcohol Capacity

TO THE EDITORS: I recently read the news item on alcohol capacity *(Modern Medicine,* Aug. 15, 1949, p. 88) which quotes Dr. Henry W. Newman as stating that:

> The maximum amount of alcohol that can be consumed daily by a man of average weight is a quart of 100-proof liquor. This maximum may be achieved only by maintaining the blood alcohol concentration at a high level, since the rate of alcohol metabolism increases with blood alcohol concentration.

This may be true of the majority of persons. However, there are notable exceptions. I know of one person who was said to consume habitually 4 or 5 qt. of whiskey per day without apparent intoxication, and I personally knew a man here in Los Angeles back in 1934 who took little water but who drank 2 to 3 qt.

(Continued on page 24)

RUTAMINAL*

the protection of **rutin** [1] the action of **aminophylline** the sedation of **phenobarbital** —for use in selected cardiovascular and diabetic conditions in which excessive capillary fragility presents a complicating hazard —bottles of 100 tablets

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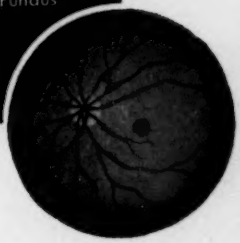
Normal Ocular Fundus



[1] In keeping with newer clinical findings, the rutin content of RUTAMINAL has been increased to 60 mg. per tablet (three times the former rutin content) at no increase in cost to the patient.

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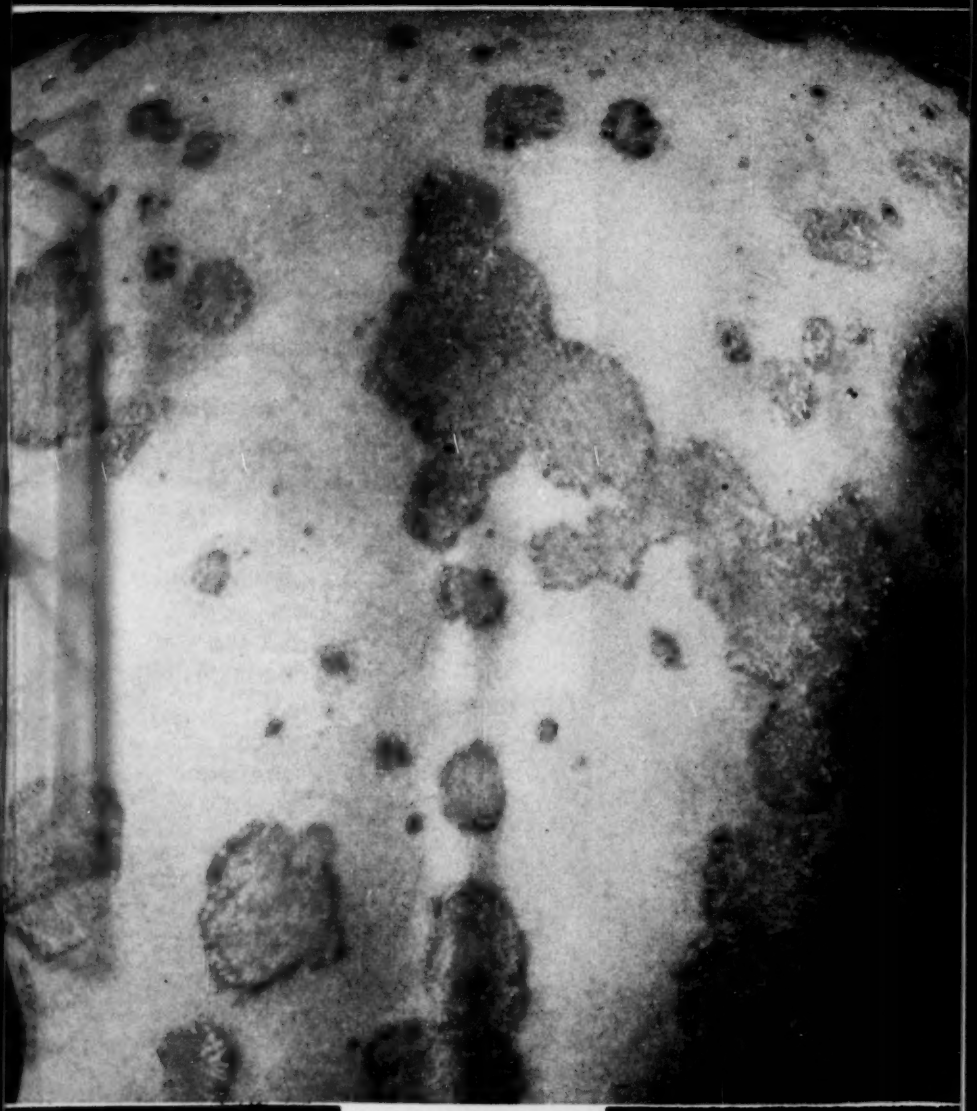

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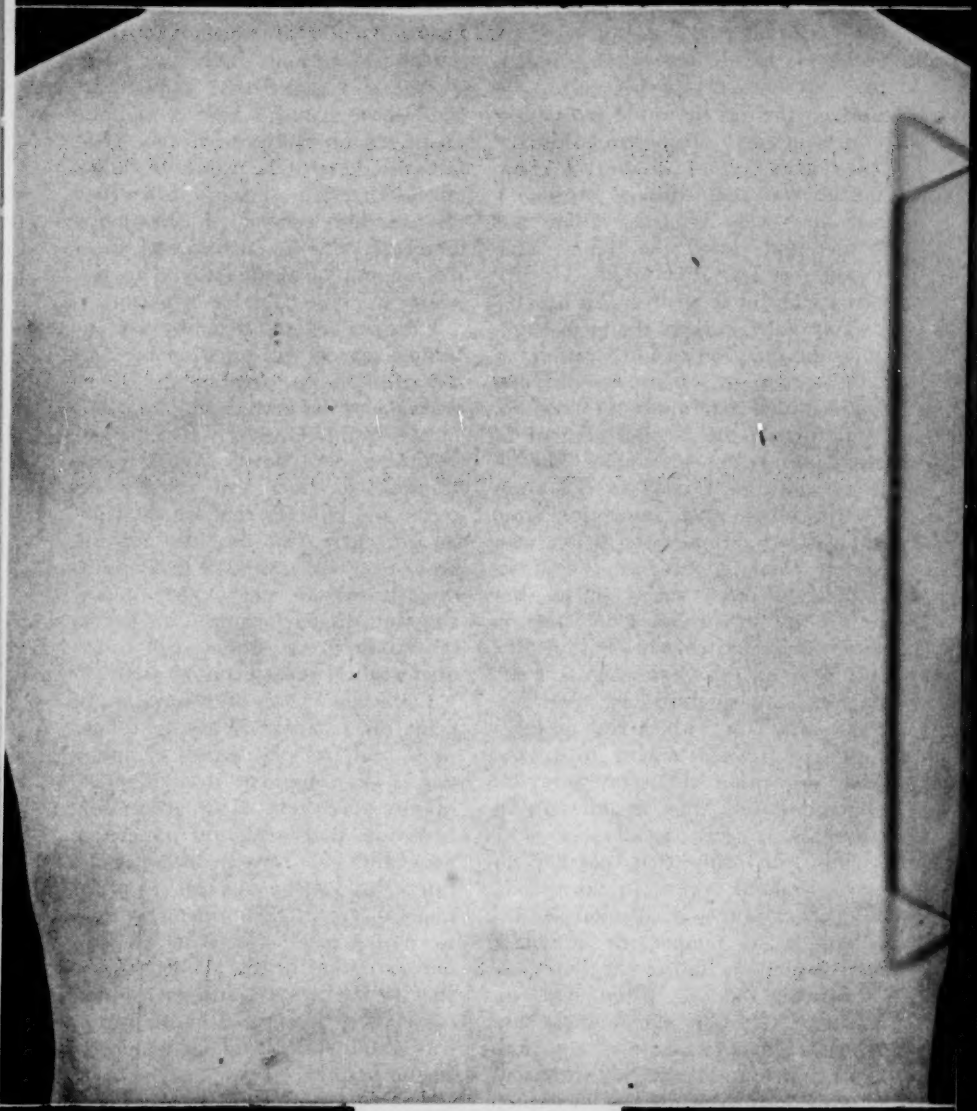

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of "Old Quaker" per day without showing evidence of intoxication.

This man was approximately forty-five years old, 5 ft. 6 in. tall, weighed about 175 lb. He kept several bottles of "Old Quaker" in his desk, and through the day he would frequently pour out and drink an ordinary water glass full of whiskey. I know that it was real whiskey because I saw the seals removed from the bottles and tasted the liquor. Five minutes or less after taking a drink one could not smell it on his breath!

Too many workers try to oversimplify the question of intoxication.

The amount of alcohol in the brain is what determines intoxication. Building up the alcohol content of the brain is not so simple. The alcohol must be carried to the brain by the blood after absorption from the gastrointestinal tract. It is a matter of common knowledge that an individual often varies in his susceptibility to alcohol from time to time, and particularly that alcohol taken on an empty stomach is usually more apt to intoxicate than that taken after, or with, a full meal.

There is good reason to believe that absorption of alcohol from the gastrointestinal tract in different individuals varies considerably. This being true, only that portion absorbed would appear in the blood.

After absorption, alcohol in the blood is [1] temporarily stored in the tissues, including the brain, [2] oxidized, and [3] eliminated unchanged through the kidneys and lungs. These factors also are probably subject to rather wide variations.

Obviously, during the absorptive stage, the blood alcohol will be higher than the brain alcohol and, during the eliminative stage, with no more alcohol being absorbed, the blood alcohol will be lower than the brain alcohol. This was well shown by a pathologist in Milwaukee, whose name I have forgotten, about ten or twelve years ago. This fact also lessens the value of blood alcohol determination in medicolegal cases. It also renders of even more doubtful value in medicolegal cases the amount of alcohol found in the urine or expired air of a person.

I do not believe that any well-informed person will question the fact that alcoholic intoxication is a direct function of the percentage of alcohol in the brain. However, if a person absorbs alcohol slowly from the gastrointestinal tract and rapidly excretes and oxidizes that which is absorbed, there will be little for the brain to absorb. Another may absorb rapidly, excrete and oxidize slowly, and thus quickly acquire a high concentration in the brain, with consequent quick, intense intoxication.

From many years of observation of man, his drinking habits and reactions, and from thousands of autopsies, I am convinced that there are infinite variations of the absorption, excretion, and oxidation pattern in man and that anyone who makes categorical statements on any one phase of the problem opens his work to serious challenge. I make only one exception to this statement, and that is the well-established, positive correlation between alcoholic intoxication and the percentage of alcohol in the brain.

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Los Angeles

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4 excerpts from the literature on Vioform

Overton "The effect of 3% Vioform in a water-miscible base or in petroleum jelly has been assessed under carefully controlled conditions on a variety of dermatoses in 176 patients. It proved a useful local application in the treatment of the following conditions: coccogenic sycosis barbae, seborrhoeic dermatitis, otitis externa, acute vesiculo-papular eczema. The incidence of cases of intolerance was low."[2]

Sulzberger & Baer "Both long clinical experience and the present studies indicate that Vioform (5-chloro-7-iodo-8-hydroxyquinoline) is a valuable remedy in topical therapy. . . . Since submitting this report we have confirmed our observations in hundreds of additional cases. The results have strengthened our conviction that Vioform preparations, while not panaceas, are among the most valuable local therapeutic agents with very low irritancy and a low index or potential of sensitization."[3]

Martin-Scott ". . . in at least 37 cases in which penicillin had failed Vioform produced the desired result. . . . It is concluded that 3% vioform is a valuable addition to the medicants at present used in this country for pyococcal dermatoses."[1]

Perlman "Its results in the treatment of infantile eczema, as well as in the eczemas of older children, have been found good . . . in fact, on occasions Vioform has been proved to be the topical answer to eczema when orthodox treatment with the tars failed."[4]

1. Martin-Scott, I.: Brit. Med. J., May 14, 1949. 2. Overton, J.: Brit. Med. J., May 14, 1949. 3. Sulzberger & Baer: Arch. Derm. & Syph., 58: Aug. 1948 4. Perlman, H. H.: J. of Pediat., July 1948

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cream 3% in a special water-washable (flesh color vanishing cream) base—50 Gm. jars and 1 pound jars.

ointment 3% in a petrolatum base (tends to stain, should be covered in use)—50 Gm. jars and 1 pound jars.

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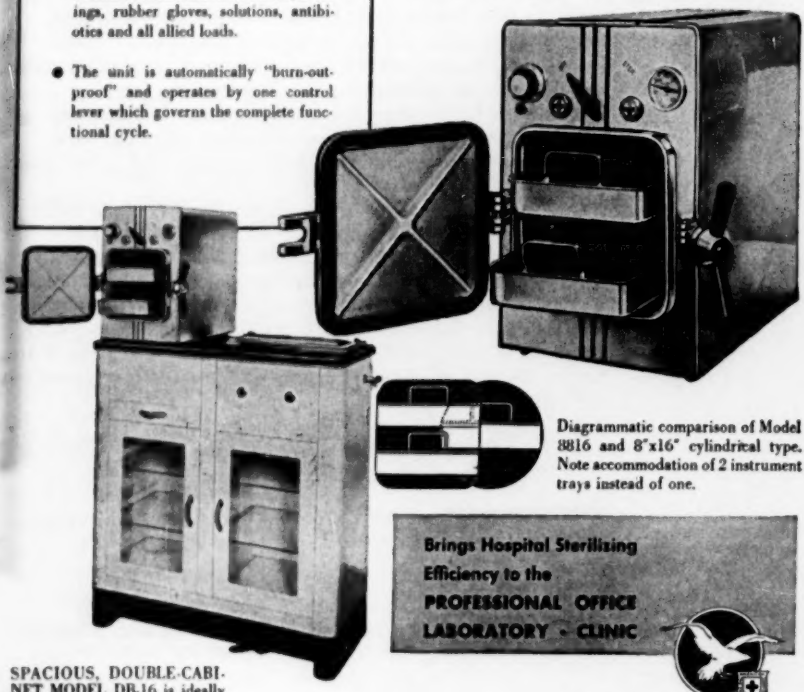

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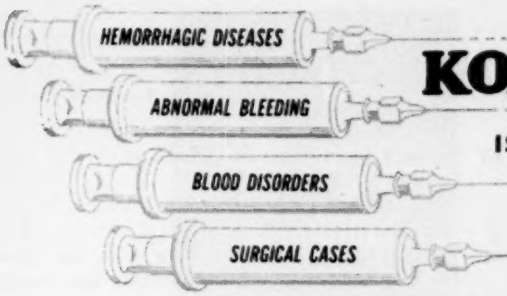

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PROBLEM: In a personal injury suit, did the trial judge properly refuse to permit a physician to testify over plaintiff's objection what plaintiff's admission record at the hospital showed concerning the cause of a previous hospitalization in another state and under another doctor's care? The record had been prepared from information given by plaintiff.

COURT'S ANSWER: Yes.

The Colorado Supreme Court decided that under the statutes of that state, which resemble those in force in most other states, "a physician without the consent of his patient is prohibited from disclosing any information however acquired in attending him" (210 Pac. 2d 214).

PROBLEM: In a malpractice suit it appeared that Dr. P, a cancer specialist, advised biopsy of an enlarged axillary lymph node. While the patient remained anesthetized, the specimen was examined in the hospital laboratory and a diagnosis of carcinoma was made. The woman's right breast was immediately removed by Dr. P, with Dr. H, resident hospital surgeon, assisting. When the operation was almost completed, the laboratory changed the diagnosis to Hodgkin's disease or lymphoma. Was the resident doctor liable for damage to the patient?

COURT'S ANSWER: No.

The California District Court of Appeal decided that defendant was not liable for the "most lamentable error" that resulted in serious injury, because there was no proof that he had committed any wrongful or negligent act. The defendant simply followed instructions of Dr. P, who determined the necessity for the operation and the time and extent of the performance. The mistake had originated in the pathologic laboratory and a jury had exonerated the pathologist in a former trial of the case. In the meantime, Dr. P had died. In short, the appellate court decided that Dr. H, as an assistant, could not be held liable for the laboratory's mistake or Dr. P's hasty decision (211 Pac. 2d 6).

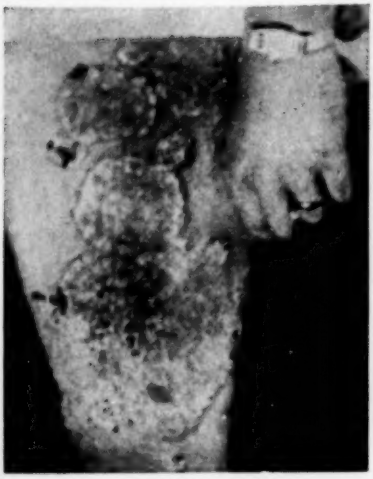
¶It appears that although courts generally hold a directing surgeon liable for damage resulting from neglect of assistants, selected or adopted by him, the assistant is not liable for the principal surgeon's fault—A.L.H.S.

PROBLEM: A dispute arose in a personal injury suit as to whether the plaintiff's disability was partly due to prior disease and injuries. Could the trial judge require plaintiff to consent to defendant's inspection of medical records covering prior treatment of plaintiff for such disease and injuries, despite a local statute disqualifying physicians from testifying without the patient's consent about confidential information obtained in treating a patient?

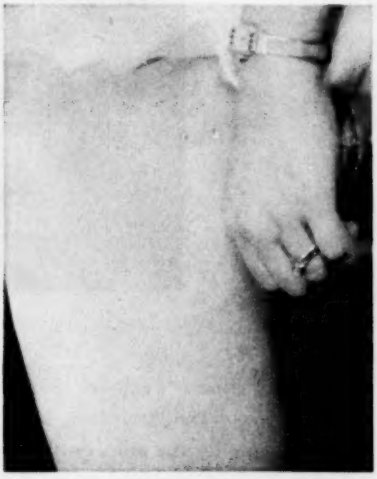
COURT'S ANSWER: Yes.

The Wisconsin Supreme Court reasoned that plaintiff should be requir-

(Continued on page 32)



Psoriasis – duration 15 years



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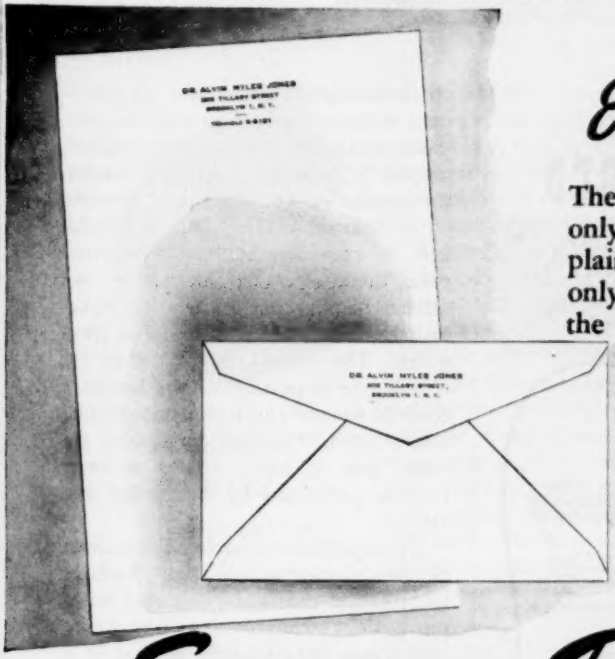

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ed to furnish to defendant all pertinent information concerning his previous disability, whether that information be possessed by him or under the control of another. As to records of a Veterans' Hospital, he could not be regarded as having control over them, but he should be required to consent to their examination by defendant's attorney or physician. The court required that he consent to inspection of the hospital records, nurses' and technicians' notes and records, attending physicians' reports, and so forth, so far as such records pertained to the prior disability.

The opinion recognizes limitations of the statutory rule that medical information cannot be disclosed without patient's consent. It is noted that the reason for the rule is that if a physician could testify without the patient's consent, the patient would be apt to conceal "vicious or uncleanly habits necessary for a physician to know in order to treat them properly" rather than be humiliated by their disclosure. If the disclosure will not "subject the patient to shame or affect his reputation or social standing, there is . . . sound reason why in the interest of truth and justice he should be compelled to disclose them. The physician's exemption from disclosure should be limited to such disclosures as would injure the patient's feelings or reputation" (39 N. W. 2d 675).

The Wisconsin court referred to its earlier decision in another case in which it was decided that, despite the statute, the following types of evidence were admissible in a court trial without the patient's consent: [1] testimony of a nurse assisting an attending physician, [2] hospital record made by a nurse on the

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Easter Island Figurine; Photo courtesy University of Pennsylvania Museum

patient's admission, used by the attending physician, and [3] testimony of an x-ray technician, including a plate made by him under the doctor's direction (276 N. W. 300).

¶Although courts in other states might agree with the conclusions of the Wisconsin Supreme Court, the summary of the decisions cited above should not be relied upon as necessarily reflecting the law in other states. For example, many courts might not concur in the view that, in the absence of specific statutory declaration, the confidential character of information acquired by a doctor from a patient is limited to information the disclosure of which would *humiliate* the patient.—A.I.H.S.

PROBLEM: After a woman had been returned to her room following a total hysterectomy, insertion of a catheter brought a discharge of mixed blood and urine. The patient and her husband both testified that, immediately after the operation, the defendant surgeon admitted that he had "nipped" the patient's bladder; the surgeon denied having made such a statement. The patient, who complained of burning, urgency, and incontinence after the hysterectomy, was examined by a urologist who found infection and calculi of the bladder but no surgical damage to the walls. Three months later, the urologist reexamined the patient and found a vesicovaginal fistula, which was later repaired by another doctor. Without expert medical testimony could a jury conclude that the first doctor had failed to use due care and skill?

COURT'S ANSWER: No.

Said the Ohio Court of Appeals: "We find no medical evidence relating to the nipping of the bladder as a probable cause of the burning, urging and incontinence, . . . or that there was any causal connection between such claimed nipping and the vesicovaginal fistula which was subsequently found" (88 N. E. 2d 76).

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Questions & Answers

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QUESTION: Recently a typical pituitary dwarf has come under my care. He is twenty-five years old. Roentgenograms reveal open epiphyses. Have you any suggestions for treatment?
M.D., California

ANSWER: *By Consultant in Internal medicine.* Theoretically, growth is possible if epiphyses are not united but, actually, results are disappointing, especially at the age your patient has attained. Extract of anterior pituitary gland, possibly combined with thyroid extract, is a logical therapy.

QUESTION: I have treated a patient with pulmonary tuberculosis with streptomycin for two years and have had good results. May treatment be continued without fear of bad reactions?
M.D., New York

ANSWER: *By Consultant in Chest Diseases.* It is impossible to give a specific answer to a question on tuberculosis in which the particulars of the case are not given.

Streptomycin is a valuable drug in the treatment of tuberculosis but has very definite limitations and must, therefore, remain part of a well-integrated program in which prolonged bed rest, the various collapse measures and even resection are carried out when indicated. After streptomycin therapy of three to four months, most patients will have organisms that are resistant to streptomycin. It has recently been shown that para-aminosalicylic acid (PAS) given in combination with streptomycin delays emergence of resistant strains. Studies should be done to determine the sensitivity of the organisms.

Reactions to streptomycin therapy must still be carefully watched for, but they are relatively few when the drug is given in optimum dosage. Dosage, in a very general way, is 1 gm. of regular streptomycin, or up to 2 gm. daily when dihydrostreptomycin is being given. Recently new programs of interrupted therapy, injections every other day or only once weekly, have been attempted and show promise of giving good results with even less toxicity.

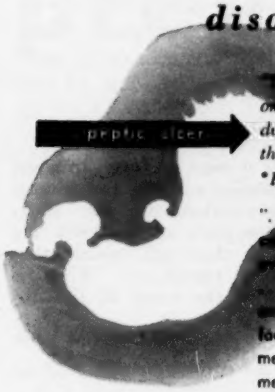
QUESTION: A healthy, twenty-eight-year-old woman noticed, about four months ago, that her breasts were becoming smaller. Her child was four years old. There have been no other physical changes. Laboratory tests, including study of ketosteroids, have been negative. Can you suggest a reason for the atrophy and possible treatment?
M.D., Ohio

ANSWER: *By Consultant in Gynecology.* Atrophy of the breast may result from hormonal changes or from loss of tissue response to hor-

compatible with the

deficiency theory

in the management of gastrointestinal disorders . . Viodenum

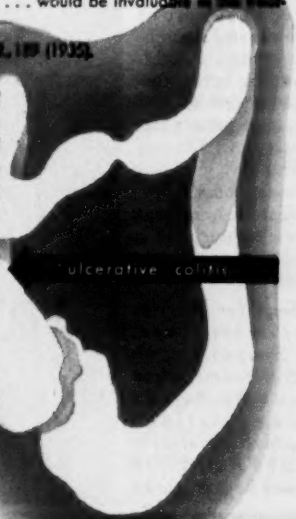


*"The treatment of . . . gastric ulcer and duodenal ulcer . . . is based on the supposition that the normal functions of the stomach and the duodenum are maintained by various biologically active substances, the absence of which favours ulcer formation."**

*Hurst, O., *Lancet*, **251**, *272 (1946).*

". . . not only were these patients relieved of their symptoms, but in all cases [] included in this particular report there was roentgenologic evidence of ulcers having healed . . . it is not expected that . . . duodenal . . . will prove to be a specific for peptic ulcer, for I do not believe that any single substance will ever be able to correct all the interacting factors responsible . . . I am fully convinced, however . . . the protecting mechanism inherent in duodenal . . . would be invaluable in the treatment of ulcer."*

*Rivers, A. D., Am. J. Dig. Dis., 2, 189 (1935).



*"A consideration of the natural course of ulcerative colitis led to the theory that in some cases the condition might arise as the result of a deficiency. Preliminary investigations suggested that the missing hypothetical factor might be present in or produced by the intestine. Feeding experiments . . . showed that remissions could be induced regularly by giving uncooked pig's small intestine by mouth . . . the results obtained with this treatment do not appear to be coincidental or psychological; they are compatible with the deficiency theory advanced . . ."**

Gill, A. M., Lancet,* **2, *(1945).*

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*Streicher, M. H., J. Lab. Clin. Med., **33,** 1633 (1948).

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monal stimulation. The case under discussion is apparently an example of postlactation atrophy. If the patient is still menstruating normally, the atrophy is probably due to change in the breast, not in the hormone system. If such is true, hormone therapy would not be of benefit. If, however, there is a coexisting amenorrhea, estrogen therapy given in cyclic manner may stimulate growth of the breasts.

QUESTION: A man of forty, in good health, has consulted me for almost constant perspiration on the back. Palms or other parts of the body are not affected. A thorough examination reveals nothing significant. What is your opinion of the cause of the disturbance?

M.D., New York

ANSWER: *By Consultant in Dermatology.* Since the patient has had a thorough examination, it can be assumed that systemic disease is not a factor in this case. Localized disturbances of perspiration are usually related to structural or functional disturbance of nerve supply to the area. Such is probably the case in this instance.

QUESTION: Has a new drug been advanced for trigeminal neuralgia?

M.D., New York

ANSWER: *By Consultant in Neurology.* No specific new treatment for trigeminal neuralgia has been devised. The drug now being used is trichlorethylene, a liquid which the patient drops on a piece of cotton and inhales. A large number of patients with trigeminal pain are relieved by this drug. Occasionally, large doses of vitamin B_1 and C have proved helpful. The best treatment, when pain is severe, is section of the fifth cranial nerve.

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1. Slaughter, D.: South Dakota J. Med. & Pharm., 1:425, 1948

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Prepared for Modern Medicine

A DANGEROUS and unjustified sense of security in the administration of anesthetics has arisen during recent years.

Despite the great advances in technic and management of anesthesia and the resulting decrease in the fatalities attributable to that agent, anesthetic disasters continue to take a considerable toll of life and health. These catastrophies are all the more tragic because nearly all could be avoided.

ASPHYXIA DURING ANESTHESIA

Most patients who die during anesthesia succumb to asphyxia. Death from this cause is in nearly every instance due to lack of technical ability and judgment on the part of the anesthetist.

Asphyxia may be due to actual obstruction of the respiratory passages, to depression of respiratory function to the point where the patient is no longer able to provide himself with adequate oxygen for survival, or to reduction of the oxygen content of the inhaled atmosphere below what is necessary for life.

Not all anesthetic calamities result in immediate death. Prolonged or severe anoxia frequently produces degenerative changes in the cerebral cortex which may terminate in death some hours or days after operation or cause mental changes

* Clinical Teacher in Anesthesia, University of Toronto; Senior Anesthetist, Toronto General Hospital.

in the survivor. These sequelae may be avoided by maintenance of an adequate airway.

Under conditions of anesthesia, most patients require at least 20% of oxygen in the inspired atmospheric air. A lesser concentration than this, if imposed for longer than a very few minutes, may result in death or crippling mental changes. Some patients require more oxygen, particularly those who are anemic or in a state of shock or who have an increased metabolic rate because of fever or hyperactivity of the thyroid. Sound judgment on the part of the anesthetist is essential to prevent disaster in such cases.

Depression of the patient's respiratory function to the point of absolute or relative asphyxia is a matter of overdosage of the anesthetic agent. Overdosage in this respect must be considered in relation to the physical status of the patient and the preoperative use of sedative drugs. This is again a matter where good judgment is of paramount importance.

Some physicians do not realize that asphyxia from respiratory depression is possible while the patient still breathes. The act of breathing does not of itself insure adequate oxygenation. If the volume of respiratory exchange is not adequate to provide sufficient oxygen from the particular atmosphere which the patient is breathing, asphyxia results. Disaster from this cause may be avoided by artificial respiration and is inexcusable today.

OBSTRUCTION OF AIRWAY

Asphyxia from blockage of the airway may be caused by simple obstruction by the tongue and epiglottis, the presence of foreign material in the airway, or laryngeal spasm. Other rare causes exist.

Many disasters have occurred because of a mistaken idea that movement of the chest is indicative of breathing. Actually, the individual who is being asphyxiated by occlusion of the airway makes violent respiratory efforts until the respiratory center finally fails because of anoxia. The only proof that breathing is really taking place is demonstration of the movement of air or anesthetic mixture into and out of the respiratory tract.

When a rebreathing reservoir bag or bellows is in use, respiration may be confirmed by movements of the bag or by

hearing or feeling the passage of air. Occlusion of the airway is a frequent cause of disaster during tonsillectomy when an endotracheal tube is not used.

Obstruction of the airway by foreign material is most frequently due to aspiration of vomitus or blood. The chances of aspiration of vomitus may be reduced by careful management of the induction period and by avoiding general anesthesia for patients who have recently taken food.

When this latter precaution is not possible, vomiting should be anticipated by the provision of adequate suction equipment and the induction of anesthesia with the patient on the side in the head-down position. A tight-fitting endotracheal tube should be used to prevent the aspiration of vomitus.

When vomiting has not been anticipated, adequate postural drainage and suction must be used to remove all vomited material from the airway.

Obstruction of the airway by inhalation of blood occurs only when surgery is performed within the airway. Most fatalities from aspirated blood are associated with tonsillectomies and adenoidectomies and may be absolutely avoided by the use of an endotracheal tube and a small gauze pack in the lower pharynx, coupled with proper positioning of the patient in the postoperative period so that blood drains from the mouth. When the anesthetist is unable to perform endotracheal intubation, great care must be taken to suck all blood from the pharynx promptly.

LARYNGEAL SPASM AND CONVULSION

Asphyxia due to laryngeal spasm occurs not infrequently. Disaster may be avoided by forcing oxygen into the respiratory tract as the glottis begins to relax. This relaxation always occurs before death from asphyxia supervenes, and the alert anesthetist is usually able to revive the patient by providing adequate oxygenation at the earliest possible moment. However, patients who are already in poor physical condition may not tolerate the period of anoxia that necessarily occurs with the spasm.

Laryngeal spasm may usually be prevented by a nonirritating induction of anesthesia, with the avoidance of stimulation of the larynx by secretions until full surgical anesthesia is

obtained, and by establishing and maintaining adequate surgical anesthesia before surgical stimulus is applied.

Convulsions during anesthesia are fortunately rare, but death following such an episode is also the result of asphyxia. The cause of such convulsions is yet obscure, but dehydration, fever, anoxia, and carbon-dioxide retention probably all contribute.

Control of the convulsion by an intravenous barbiturate and by adequate artificial ventilation with oxygen should prevent a major disaster.

SPINAL ANESTHESIA

Death during spinal anesthesia is rarely due to an idiosyncrasy of the drug used. The usual cause is anoxia from deficient circulation coupled with diminished respiration because of paralysis of intercostal muscles.

This disaster may be avoided by proper control of the blood pressure through the use of vasopressor drugs and of parenteral fluid therapy and the administration of oxygen.

Among the disasters associated with spinal anesthesia, too little mention is made of meningitis resulting from infection and of permanent neurologic damage caused by mechanical and chemical factors. Scrupulous attention to the details of asepsis in the technic of inducing spinal anesthesia is essential.

Mechanical injury to the spinal cord rarely if ever occurs when the site of puncture is below the second lumbar interspace. Damage to nerve roots may be avoided if the lumbar puncture needle is kept in the midline.

Most instances of chemical damage to the central nervous system following spinal anesthesia may be traced to contamination of the drug with alcohol or some similar solution used to sterilize the ampule. Cracked and defective ampules cannot be entirely eliminated, but contamination is readily detected before the injection is made if ampules are sterilized in highly colored solutions.

EXPLOSIONS

The most spectacular but least frequent accidents associated with inhalation anesthesia are explosions. All the agents commonly used for inhalation anesthesia will explode under

clinical conditions, with the exception of nitrous oxide, chloroform, and trichlorethylene.

Explosion of an anesthetic mixture may cause immediate death from disruption of the pulmonary alveoli or later death from burns in the respiratory tract. Such catastrophies may be prevented by precautions which prohibit the accumulation of static charges in operating rooms and the avoidance of explosive anesthetic mixtures when open flames and open electrical equipment are used.

Aureomycin Therapy of Herpes Zoster

MAXWELL FINLAND, M.D., EDMUND F. FINNERTY, JR., M.D., HARVEY S. COLLINS, M.D., JOHN W. BAIRD, M.D., THOMAS M. GOCKE, M.D., AND EDWARD H. KASS, M.D.*

AUREOMYCIN is apparently specific for herpes zoster but should be given in the early or active phase.

If treatment is started within two weeks after the first eruption, Maxwell Finland, M.D., and associates of Harvard University and Tufts College, Boston, find that postherpetic pain can usually be prevented.

The drug was given for initial, acute, or late involvement in 24 cases. Cervical, thoracic, and lumbar segments were affected as well as branches of the trigeminal nerve. In a few instances lesions were generalized.

A total daily dose of 4 gm. is taken orally, 1 gm. after each meal and at bedtime, for two to four days or until lesions are well dried and encrusted. During the next three to five days, 0.5 gm. is administered four times daily.

The smaller dose may be given throughout the course when the regular amount is not tolerated. If preferred, 500 mg. is injected by slow intravenous drip in 500 or 1,000 cc. of 5% dextrose solution without alkaline buffer. The procedure usually takes about an hour.

Vesicles heal rapidly and completely. New lesions occasionally appear during the first day of treatment but not later unless the course is interrupted. Pain also subsides after the first day.

Aureomycin was not beneficial in 4 cases of herpes labialis. The lesions extended during therapy.

* Aureomycin treatment of herpes zoster. New England J. Med. 241:1037-1047, 1949.

Venous Stasis in the Legs

W. J. Merle Scott, M.D., and Michael Radakovich, M.D.*
University of Rochester, N.Y.

Chronic ulcerative lymphedema of the legs may be diagnosed by a simple volumetric technic even when the superficial veins can be neither seen nor felt.

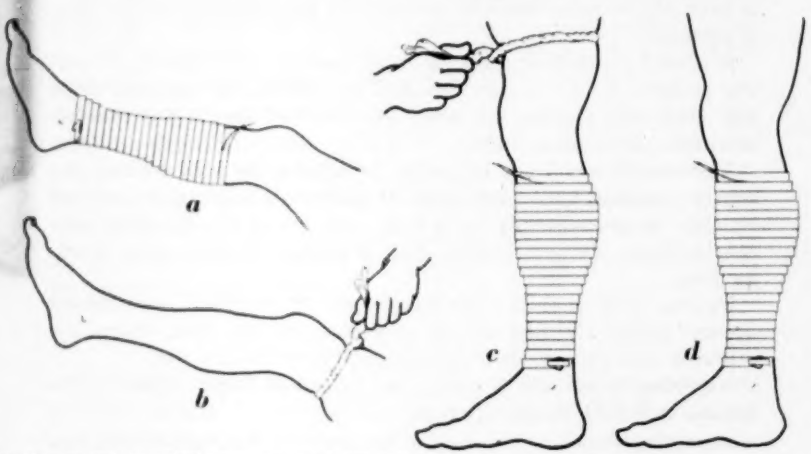
The lymphedema and venous stasis are effectively controlled by a pneumatic bandage which exerts uniform, rhythmic pressure by means of an inflatable bladder in a nonelastic sheath.

VENOUS STASIS TEST

When varicose veins are concealed by induration of skin and subcutaneous tissues, ordinary tests of vascular function may be impossible. However, incompetence of perforating vessels is often shown by the differences in measurements of the leg after changes in position, explain W. J. Merle Scott, M.D., and Michael Radakovich, M.D.

Enlargement is quickly and accurately estimated with a 25-foot cloth tape measure wrapped from ankle to knee.

The leg is measured first with the patient supine. After the limb has been raised at a 45° angle and held in that position for five minutes, the end of the tape is fastened with adhesive 2 in. above the external malleolus, and twenty parallel turns are made (Fig. a). The tape should rest against the skin without tension and the turns should not overlap. The terminal point directly in line with the initial point is marked and a direct reading is made from the tape.



* Venous and lymphatic stasis in the lower extremities. Surgery 26:970-986, 1949.

The tape is removed and a tourniquet applied to occlude superficial veins (Fig. b). The subject stands for a second measurement (Fig. c). Tourniquet and tape are removed, and after five minutes of standing, the multiple circumferential measurement is again made (Fig. d). The first measurement is then repeated.

Venous stasis is indicated by an increase of more than 6 in., particularly on standing with the tourniquet. The greatest increase is always on the second measurement and may be as much as 20 in. If varicose veins are prominent and perforating veins competent, volume does not increase much until the tourniquet is removed.

LEGGING

Stasis is controlled by application of uniform pressure obtained with the Aero-pulse legging which has an outer casing of Cape Cod duck closed with a zipper. A butterfly-shaped rubber bladder fits into an inner pocket and is inflated through a tube and valve at the legging top. The hand pump used for inflation has a regulator which controls air pressure.

In most cases a level of about 35 mm. of mercury is adequate. The balloon pulsates and pressure is raised by contraction of calf muscles during walking and reduced below the initial level by intervals of relaxation. Pulsation is applied uniformly over the entire lower leg. Exercise is beneficial rather than detrimental and ulcers may heal more rapidly than with bed rest.

If ulcers are below the malleoli, more pressure is sometimes needed in that area. A second small bladder can be inflated to a level of 50 mm. while the large container remains at 35 mm.

Bacterial or fungous dermatitis occasionally requires special treatment while the legging is worn or, in extreme cases, before the device can be applied. Perspiration is absorbed with a cotton understocking and, if necessary, by a layer of Cellu-cotton or an old Ace bandage loosely wrapped. An insulating layer of inert plastic or cellophane may be used if the patient is allergic to the rubber.

The support is not used when the leg is elevated. After circulation improves, the bandage can safely be removed during active periods of one to three hours daily. However, stasis develops and ulcers quickly reappear if treatment is discontinued.

GUAIAC TEST FOR OCCULT BLOOD in the feces is suitable for office use and easy to employ. A preliminary meat-free diet is not required. In the technic used by Stanley O. Hoerr, M.D., William R. Bliss, M.D., and James Kauffman, M.D., of Ohio State University, Columbus, a bit of feces is smeared directly onto simple filter paper. Then 1 or 2 drops of each of the three reagents, guaiac solution, glacial acetic acid, and hydrogen peroxide, are added in sequence. Color change to blue or dark green within thirty seconds denotes presence of blood.

J.A.M.A. 141:1213-1217, 1949.

Chilblains

JOHN T. INGRAM, M.D.*
General Infirmary, Leeds, England

No therapy is specific for chilblains, but empirical treatment, varied to suit the individual, will relieve all but a few patients.

Chilblains are an expression of an individual susceptibility to react to cold in a particular pattern. Impaired peripheral circulation predisposes to chilblains. The tendency is influenced by many different factors, internal and external, and may be affected by prophylactic measures, believes John T. Ingram, M.D.

PROPHYLAXIS

Warm clothing, particularly on the extremities, prevents or modifies the effects of cold and humidity which precipitate vascular changes. Two pair of socks for men and elastic understockings for women may be advisable in winter. Clothing should not be tight and binding.

Exercise is important in the maintenance of circulatory tone. Feet or hands which have become cold should not immediately be exposed to warmth from fire or hot bottles.

TREATMENT

Stimulation of circulation by electrical and radiation therapy, massage, and passive and active movements is often effective for chilblains.

An attack may be relieved by ultraviolet light therapy or by fractional doses of x-rays, but these measures should not be employed by the inexperienced.

The only benefit of local stimulants appears to be derived from the accompanying massage. Irritation from local applications may cause dermatitis or blistering.

Calcium, calciferol, thyroid, and nicotinic acid may be helpful but the exact action of some of these drugs is not known. No scientific evidence supports the claims made for calcium, but patients who demand such treatment may obtain psychologic benefit.

A high level of calciferol in the blood is not protective, but the metabolic shock of a massive dose may have some effect. If employed at all, this measure should be used with care and only for a short period.

Small doses of thyroid extract are often helpful by improving the circulation. Nicotinic acid acts as a peripheral dilator. Purgatives may abort an attack.

For cases which persist in spite of medical treatment, sympathectomy may be indicated. Otherwise, removal to a different climate may be the only solution.

DIAGNOSIS

Most commonly, chilblains appear as an itching, erythematous, and congested superficial swelling on the fin-

* Refresher course for general practitioners: chilblains. Brit. M. J. 4639:1284-1286, 1949.

gers and toes. The aspect may differ somewhat on the breast, buttocks, upper arms and lower legs, where the lesions are large and more diffuse. When the ear is involved, little swelling is possible, and burning, irritation, blistering, and atrophy or calcification occur instead.

The young, particularly at puberty, are most susceptible. Chilblains are rarely seen during pregnancy.

To be differentiated are:

► *Erythema nodosum*—This condition often follows a respiratory infection and is usually distinguished by tenderness, pain, and pyrexia.

► *Erythema induratum*—Lesions are more deep seated than those of chilblains. The skin may ulcerate, but does not itch.

► *Drug rash*—Eruptions are usually larger and more scattered than with chilblains and are symptomless.

► *Erythema multiforme*—Lesions are spread more profusely in a particular pattern and cause less irritation than with chilblains.

► *Lupus erythematosus*—Eruption is usually more defined than chilblains and appears on the backs of the fingers, commonly between the joints and about the nail folds.

DIAGNOSIS OF MUMPS is assured when gelatinous edema is found peripheral to enlargement of the parotid or submaxillary glands. If the margin of the edematous region is gently tweaked, the area quivers like jelly. A similar type of edema, not caused by mumps, is occasionally found in other soft tissues, as with insect bites or poison ivy. However, George Heller, M.D., of Englewood, N. J., has never seen a like swelling in any infection which might be confused with mumps.

Am. J. Dis. Child. 78:903-905, 1949.

WHOOPING COUGH is effectively treated by chloramphenicol. The antibiotic is usually administered orally, but Eugene H. Payne, M.D., Detroit, and associates of the Inter-American Coprorate Service of Public Health, Cochabamba, Bolivia, find that results are equally good when the drug is given rectally as a suppository or intravenously as a solution in propylene glycol. Fever usually disappears during the second day of treatment and paroxysms on the third to sixth day. A light cough may persist for several days longer, probably because of residual inflammation in the tissues. One week after therapy, culture of cough plates of 50 children who had had severe involvement indicated that all were free of infection. The only side effect, noted in a few children under six months of age treated orally, was slight nausea, which may have been caused by the disagreeable taste. The total rectal dosage ranged from 1.5 to 4.5 gm., depending on the weight of the child.

J.A.M.A. 141:1298-1299, 1949.

Brain Tumors in Children

A. Earl Walker, M.D., and Theron L. Hopple, M.D.*
Johns Hopkins Hospital, Baltimore *Toledo*

Intracranial tumors found in childhood differ in symptoms, pathology, and course from those of adult life.

The majority arise along the medulla, pons, and third ventricle and soon block the exit of ventricular fluid, causing internal hydrocephalus. In a series of 100 cases with onset before the sixteenth birthday, most of the growths observed by A. Earl Walker, M.D., and Theron L. Hopple, M.D., lay beneath the tentorium.

Many lesions occurred during the sixth year, particularly medulloblastomas. No acoustic neuroma or pituitary adenoma was noted and meningioma was relatively rare.

Since a child's brain has great compensatory power, a tumor frequently produces no symptoms until large enough to cause intracranial hypertension by mass, blockade of ventricular fluid, or both. In babies and young children cranial sutures separate and the head enlarges.

At older ages the skull is rigid and the brain is molded into all crevices, replacing cerebrospinal and ventricular fluid, squeezing liquid from interstitial spaces, and constricting the arteries. Cerebellar tonsils may herniate about the medulla oblongata into the occipital foramen and seriously depress vital functions.

The general prognosis for a child with brain tumor is rather poor, yet cerebellar astrocytomas and some of the cerebral tumors may be removed successfully.

As symptoms are often nebulous and misleading, all available diagnostic technics should be employed.

Vomiting occurs with or without nausea, sometimes suggesting gastrointestinal disease. The symptom is often precipitated by illness or a head injury and may stop suddenly for weeks, then start again with or without provocation.

Headache is not specific but is frequently referred to the frontal region, and occipital or suboccipital discomfort is common. Pain typically starts early in the morning, often with vomiting, which may give relief. Aggravation by stooping, coughing, or straining while at stool is rarely described.

Staggering gait, the third most frequent symptom, is likely to begin

* Brain tumors in children. J. Pediat. 35:671-687, 1949.

gradually and be attributed to weakness from vomiting.

Convulsions, which often result from cerebral growths, resemble idiopathic epilepsy and are usually generalized, but may start with jerking of the face, arm, or leg. Posterior fossa tumors occasionally cause attacks of rigid opisthotonos, sometimes with respiratory and cardiac involvement.

Sutural diastasis of infants and small children may be palpated or recognized by a cracked-pot percussion note.

Weakness of an extremity, side of the face, or eyelids localizes the neoplasm, as a rule, but diplopia indicates generalized pressure affecting the abducens nerve.

In all suspected cases of brain tumor, roentgenograms of the skull should be made in anteroposterior and lateral stereoscopic views. The lesion may be located by open sutures, calcification, calvarial distortion, or erosion. If the site is in doubt, special films of the optic foramen are made. The wrist should be examined for a lead line.

Electroencephalography is done, chiefly to show cerebral tumors and exclude epilepsy.

In older children, both site and type of growth may be determined by angiography; the common carotid artery, occasionally the vertebral artery, can be punctured through the skin. Vessels of babies may be inaccessible.

Pneumoencephalography is useful and safe if intracranial pressure is not elevated. With high pressure, ventriculography is preferable but may cause circulatory changes unless the tumor is immediately removed.

Neoplasms can be distinguished from other diseases in 90% of cases. Among the conditions to be differentiated are chronic inflammatory or toxic states, such as meningeal tuberculosis or parasitic granuloma; congenital anomalies with hydrocephalus; and trauma causing subdural hematoma.

To determine the site and nature of brain tumor in a child may be difficult or impossible. With no focal signs, the lesion is probably in the posterior fossa or third ventricle. In the latter site, malignant growth is practically certain.

In doubtful cases, the posterior fossa is explored. If no tumor is found, a Torkildsen ventriculostomy is done, and roentgen therapy is applied.

BACTERIAL PNEUMONIA in children usually subsides quickly with Chloromycetin therapy. Fever of pneumococcal, streptococcal, or unclassified type commonly disappears in three days or less, and pulmonary lesions resolve in about six days, find Adrian Recinos, Jr., M.D., and associates of the Children's Hospital, Washington, D.C. When from 50 to 220 mg. of Chloromycetin per kilogram of body weight was given daily by mouth in capsules or syrup to 32 patients, all but 1 recovered promptly. The only unfavorable reaction was slight temporary depression of leukocytes

New England J. Med. 241:733-737, 1949.

Hyperthyroidism after Sixty

ELMER C. BARTELS, M.D., AND J. W. KINGSLEY, JR., M.D.*
Lahey Clinic, Boston

SIGNS and symptoms indicative of hyperthyroidism in elderly patients are often insignificant or are interpreted as the effects of old age. Yet 12% of all cases of the disease occur after the age of sixty years. As in the earlier decades, females predominate, the ratio being 4 women to 1 man.

Besides an enlarged thyroid, the most distinctive sign of hyperthyroidism in the aged is increased warmth of hands and body, observe Elmer C. Bartels, M.D., and J. W. Kingsley, Jr., M.D.

Hyperthyroidism due to a toxic adenomatous goiter occurs more frequently than primary hyperthyroidism. Although almost all such persons gradually lose weight, the chief symptom noted by the patient is usually general weakness or debility. Exertional dyspnea and palpitation are common.

Patients with primary hyperthyroidism usually first notice a rapid weight loss. Muscular weakness and cardiac palpitation are also often described.

Nervousness and emotionalism appear in but a small percentage of cases, whether the disease is primary or secondary. Usually the appetite is unchanged but anorexia is more common than increased appetite. Extended fingers often display the typical fine tremor.

A nodular goiter is usually readily palpable, but with primary hyperthyroidism the gland is often only slightly enlarged.

Tachycardia is rare. A resting pulse rate in excess of 120 per minute is the exception in the elderly hyperthyroid patient. Auricular fibrillation occurs about one-third of the time with toxic nodular goiter. One-fifth of patients with primary hyperthyroidism have this arrhythmia.

Congestive heart failure is apparent in 14% of the cases of primary thyrotoxicosis, and in 19% of secondary hyperthyroidism.

Clinically, hyperthyroidism in the geriatric patient may be called apathetic. However, the elevation in the basal metabolic rate is similar in degree to that found in young patients. Over half of old thyrotoxic and 40% of secondary hyperthyroid patients have basal metabolic rates of 40 or above.

Therapy is begun with a thiourea compound; 600 mg. of thiouracil or 200 to 300 mg. of propylthiouracil is usually given daily. This dosage causes the basal metabolism rate to decrease about 1% each day in primary hyperthyroidism. The return to euthyroidism is slower with toxic adenoma.

In many cases, in order to help prepare the patient for surgery, propylthiouracil therapy is continued for

* Hyperthyroidism in patients over sixty. Geriatrics 4:535-540, 1949.

some time after the basal metabolism rate has regressed.

With a diffuse toxic gland, Lugol's solution is given for three weeks before surgery. For auricular fibrillation, preoperative digitalization is indicated.

A one-stage subtotal thyroidectomy is performed. With proper medical preparation, the postoperative morbidity is slight. Of 123 patients thus treated only 1 died. Most patients are able to leave the hospital six days after operation.

The usual complications of thyroidectomy must be watched for. Postoperative myxedema requires thyroid extract.

Functional Sterility and Amenorrhea

RITA S. FINKLER, M.D.*

IRRADIATION may be preferable to hormone therapy for pituitary-ovarian hypofunction.

Therapeutic effects in functional sterility and amenorrhea are achieved much more quickly and slightly more often by roentgen rays than by gonadotropins, explains Rita S. Finkler, M.D.

Endocrine deficiency was observed in 190 married or single women at the Beth Israel Hospital, Newark, N. J. Among the group desiring children, conception took place after irradiation in 35% of cases and after medication in 34%. Menstruation was restored in 46% of patients given irradiation and in 41% of those given hormones.

The endocrine status is determined by endometrial biopsy, vaginal smears, basal temperatures, and urinary gonadotropin titers.

Equine or anterior pituitary gonadotropins are injected four to six times daily or on alternate days in doses of 200 to 500 units in the first half of the cycle. Chorionic gonadotropins may be given in the second half or combined with anterior pituitary in the first. Hormones are sometimes continued six or eight months.

Since irradiation is not advisable after conception, courses for menstruating women are begun just after the last period, and intercourse is banned during treatment. With amenorrhea, a preliminary Friedman test is done.

Therapy requires 200 kilovolts, with 0.6 mm. copper and 1 mm. aluminum filtration at 50-cm. target-skin distance. The half value layer is 1 mm. copper. Ovarian fields are 8 by 10 cm. and pituitary 6 by 8 cm. In most cases 4 treatments are given in two weeks, and each organ receives 80 r.

* Evaluation of hormonal and radiation therapy in 190 cases of functional sterility and secondary amenorrhea. Am. J. Obst. & Gynec. 58:559-564, 1949.

Causes and Effects of Eclampsia

CHARLES I. BRYANS, JR., M.D., AND RICHARD TORPIN, M.D.*
University of Georgia, Augusta

SOME constant environmental or dietary condition is more likely than inherent physiologic weakness to cause eclampsia of pregnancy. Because the etiologic agent is unaltered, toxemia is apt to reappear with subsequent pregnancies and to increase the chances of abortion or stillbirth.

Charles I. Bryans, Jr., M.D., and Richard Torpin, M.D., believe that eclampsia is neither a manifestation nor a cause of chronic nephritis or hypertensive cardiovascular disease, although either of these conditions may precede an attack of eclampsia and possibly render the patient susceptible to toxemia.

For an average of twelve years, data was collected on 243 women with eclampsia during pregnancy; 138 were white and 105 Negro. After the eclamptic gestation, 188 of the women had a total of 565 pregnancies.

Over half the patients were toxemic at least once again.

Nearly one-fourth of conceptions occurring after the first toxic pregnancy resulted in abortion or stillbirth. Apparently, fetal mortality for women subject to eclampsia is almost twice the rate for the general population.

True eclampsia was repeated in almost 1 of 20 cases, or at least 7 times as often as is expected in usual birth statistics even by the most conservative estimate. Before the original severe attack, however, toxemia was no more frequent than for all parturients.

Of the 243 women, 27 died within one to twenty-eight years. Approximately 14% of these succumbed to eclampsia, 15% to chronic glomerulonephritis, and 18% to cardiovascular disease.

The incidence of hypertension was not remarkably high, although younger women of the eclamptic group were more often involved than would be expected in an unselected sample. Both before and after the original severe attack of toxemia, the hypertensive group actually had fewer instances of toxic pregnancy, abortion, and stillbirth than those with normal postpartum blood pressure.

Thus eclampsia does not cause hypertensive cardiovascular disease. However, the toxic state perhaps aggravates an established vascular disorder, so that cardiovascular symptoms appear earlier than usual.

Convulsions nearly always result from long-neglected toxemia, hence conclusions drawn for eclampsia probably hold for preliminary phases. No permanent vascular lesions may then be expected from either preeclamptic or eclamptic toxemia. If hypertension is observed after a pregnancy with nonconvulsive involve-

* A follow-up study of two hundred forty-three cases of eclampsia for an average of twelve years. Am. J. Obst. & Gynec. 58:1054-1065, 1949.

ment, the supposedly preeclamptic condition may have been essential hypertension from the start.

However, true preeclamptic toxemia can and does occur after eclampsia. Women with normal blood pressure after the episode subsequently had about 3 pregnancies, of which more than one-third were toxemic. In a lengthy period of observation, any latent or potential hypertensive cardiovascular condition would certainly have become evident, and the toxic state must therefore result from some other cause than essential hypertension.

A Nonmoving Ligature-Holding Bobbin

JOHN DEVINE, M.D.*

THE principal of the fisherman's spinning reel, in which the line is peeled from the end of a stationary spindle, has been adapted to a ligature-holding bobbin by John Devine, M.D., of Melbourne, Australia.

The bobbin has no moving parts. Resistance, as the suture material is drawn out, is almost imperceptible, and snarling and jamming are avoided.

The bobbin, made of solid chromium-plated brass, consists of a core or spool and an outer casing. Stainless steel threaded tubes of any shape or length may be fitted to the end of the outer casing as a ligature carrier.

When necessary or desirable to tie at a depth with the suture material at the ligature carrier point, as in a tonsillectomy, braking pressure is applied by pushing the inner bobbin from the rear, so that the suture material is held between the inner bobbin and the edges of the end hole in the outer casing.

For underrunning vessels, as in an appendectomy or gastrectomy, the bobbin can be used alone or with a 3-in. slightly curved ligature-carrier, which can be braked by the thumb while the bobbin is held in the hand.

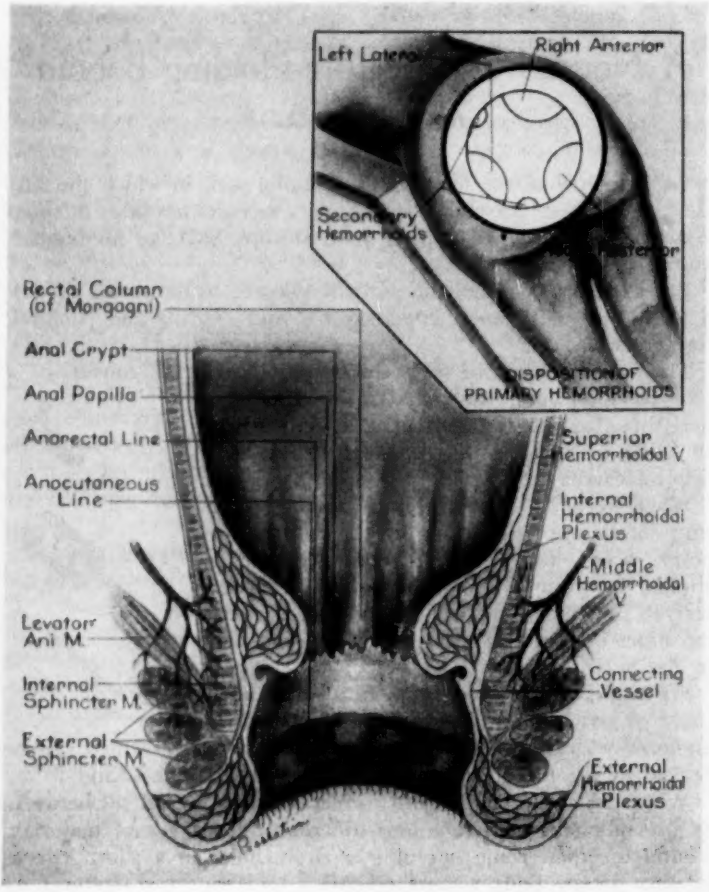
When ties are to be used in two places and the vessel cut between, as in saphenous vein ligations, different colored suture materials, wound together, come out of 2 separate holes in a short, curved ligature passer. Thus, when the vessel is underrun, two ligatures are placed at once and the variation of colors helps to prevent their being crossed.

* A ligature-holding bobbin without moving parts. M. J. Australia 2:675-676, 1949.

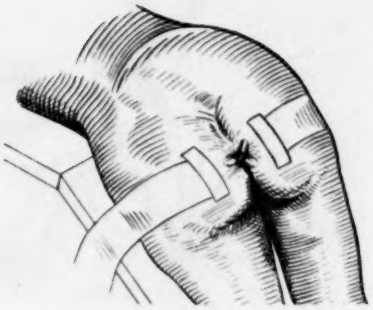
SURGICAL TECHNIGRAM

Hemorrhoidectomy

F. M. Al Akl, M.D.
Kings County Hospital, New York

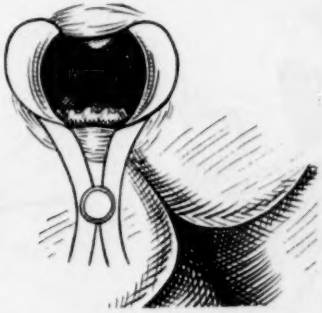


KEEP THIS PICTURE IN MIND

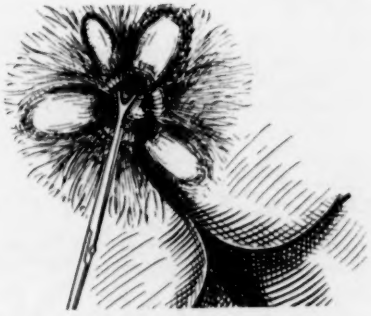


1. Place patient face down; adjust table to lower trunk and elevate buttocks. Fix gluteal fold open with T adhesive straps.

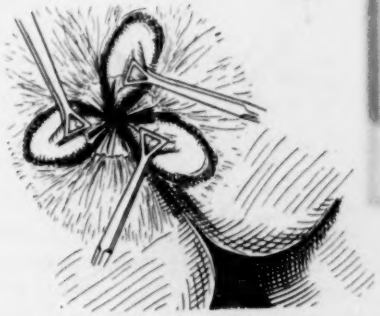
2. Paint and drape field. Lubricate gloved finger; palpate anal canal and rectal wall.



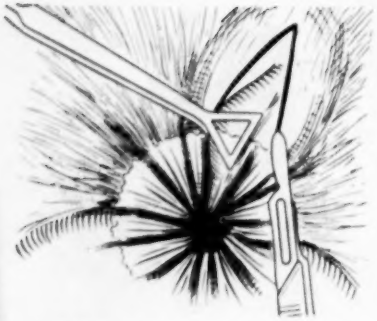
3. Insert bivalve speculum and gently dilate anorectal ring. Rotate speculum and inspect anal canal and rectum.



4. Insert small sponge on holder into rectal ampulla and rotate; gently pull out on holder, exposing extruded hemorrhoidal masses and redundant mucosa.

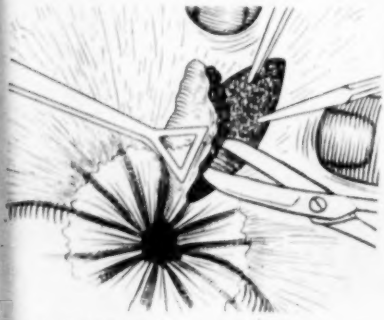


5. Apply triangular clamp radially to crest of each presenting primary hemorrhoid, and to secondary masses when present. Withdraw spongestick.



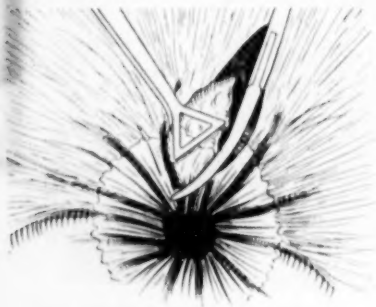
6. Lift triangular clamp and make acute V-shaped incision from outer angle of hemorrhoidal ridge to beyond anorectal line.

7. Reflect anoderm from mass as assistant opens V with fingers. Clamp bleeders.

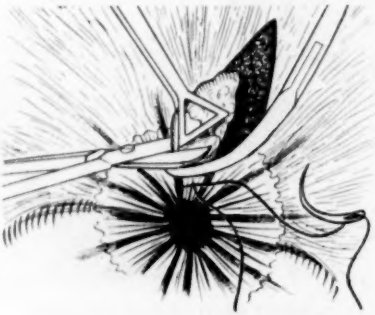


8. Continue dissection with scissors, freeing undersurface of hemorrhoidal mass from subcutaneous band of external sphincter.

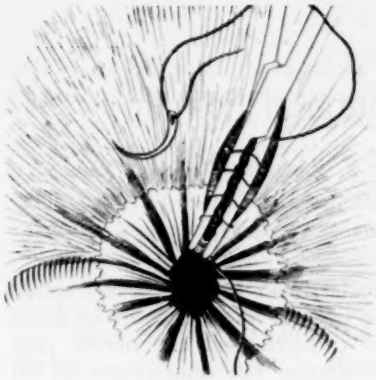
9. Transfix pedicle containing hemorrhoidal vessels; ligate and excise mass distal to ligature. Tie bleeders and cut ligature.



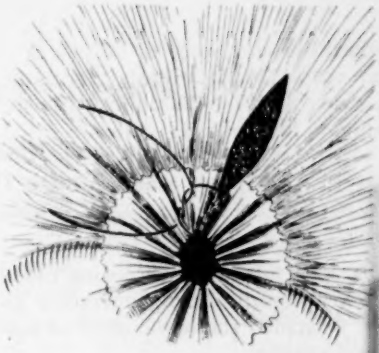
10. When mucosa is redundant, clamp mass radially after hemorrhoid is dissected free.



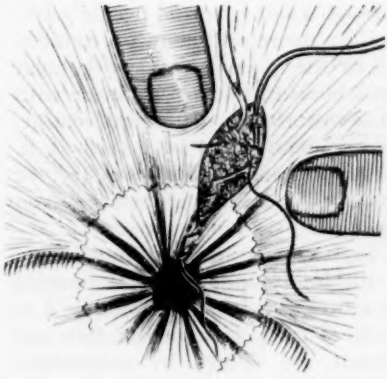
11. Pass suture ligature below tip of clamp transfixing edge of mucosa containing vessels. Tie ligature and excise mass.



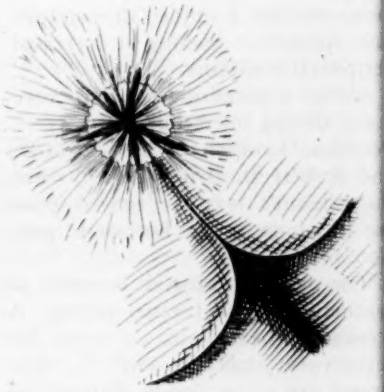
12. Whip rest of suture loosely over clamp. Open and withdraw clamp.



13. Pull on suture and tie ends together; inspect for bleeding. then cut ligature.



14. If suture line is long or retracts too far into rectum, pull taut and anchor beyond sphincteric band and tie.



15. Repeat procedure on remaining hemorrhoids, leaving intact strips of anoderm between incisions.

NOTES

With regional anesthesia, the jackknife position affords good exposure and an accessible operative field. When general anesthesia is administered, the lithotomy position is easier for the patient.

Neat incisions and careful dissection of hemorrhoidal masses without crushing or macerating anoderm reduce patient's discomfort. Oily anesthetic injections and rectal tubes are unnecessary when the dissection is clean and the edges of the anoderm undamaged.

Blood Pressure and Surgical Position

L. H. Peterson, Kenneth F. Eather, M.D.,
and Robert D. Dripps, M.D.*
University of Pennsylvania, Philadelphia

A new method of recording blood pressure during operation instantly shows the effect of postural change.

Intra-arterial and pulse pressures are traced from beat to beat by the compact mobile ink-writing manometer and a small plastic catheter of special design. The pulse wave shows whether a sudden drop results from splanchnic pooling or decreased peripheral resistance.

Abrupt hypotension has often been noted during operations, state L. H. Peterson, Kenneth F. Eather, M.D., and Robert D. Dripps, M.D., when the patient's legs are moved from the lithotomy to the horizontal position.

The flexible catheter is made of synthetic polyvinyl resin tubing. A section is heated in an oven for seventy-two hours at 110° C., then drawn out to an inside diameter of about 0.2 mm.

A 1-cc. tuberculin syringe with a 22-gauge needle and hollow steel plunger is used to insert the catheter. One end of the plunger has a nipple for attachment of the catheter, and the other end fits a capacitance manometer with small volume displacement.

The syringe barrel is filled with sterile physiologic saline solution, the needle thrust into the blood vessel, the plunger pushed down to inject the catheter, and the needle then withdrawn. The catheter can be left in the artery for hours without harm.

The manometric system is previously flushed with anticoagulant solution and during use receives a small amount from a pressure reservoir through a side tube and needle valve.

Since the recording unit is connected to the patient only by 3 small flexible leads, tracings are made with little disturbance of surgical routine. The apparatus can be moved 20 ft. away, shifted from one subject to another by change of catheter, and operated by a single person.

Even among healthy individuals, a tilt from supine to erect position produces circulatory collapse in 8 to 10% of cases. If vessels in skin and muscle are dilated by sympathetic blockade or resection, heat, or other means, the reaction is more severe. After intramuscular administration of 15 mg. of morphine sulfate, tilting may cause profound hypotension in about half of patients.

The patient under sedation or deep anesthesia during surgery is thus susceptible to postural change. After a vaginal procedure, perineal prostatectomy, or other operation, lowering of raised legs may reduce

* Postural changes in the circulation of surgical patients as studied by a new method for recording the arterial blood pressure and pressure pulse. Ann. Surg. 131:23-30, 1950.

systolic blood pressure as much as 60 mm. of mercury. A sharp decrease is likely after excessive hemorrhage or prolonged elevation causing anoxic damage to blood vessels.

To correct hypotension, legs may be raised at the hip without moving the trunk, held up about two minutes, lowered, and if necessary lifted once or twice more at short intervals. For failure due to peripheral vasodilatation, this maneuver is physiologic and acts more rapidly; it succeeds more often than pressor drugs. Circulation is improved without the respiratory embarrassment of the Trendelenburg position.

If the fall in blood pressure results from collection of blood in the viscera and diminished stroke volume, both postural change and pressor drugs may be useless.

To determine the nature of circulatory collapse, the pulse pressure contour should be analyzed. With lowered peripheral resistance and pooling in the extremities, the height of systolic rise is practically unaltered, but the rate of diastolic fall is more rapid than before blood pressure dropped. Peripheral constriction and lessened stroke volume reduce the systolic rise and broaden the peak.

SERUM ACID PHOSPHATASE should not be determined for twenty-four hours after prostatic massage. Within the first hour after massage, values may increase to those for widespread prostatic cancer, report Ernest Hock, M.D., and Roland N. Tessier, M.D., of the Wilson Memorial Hospital, Johnson City, N. Y. Effects of massage were noted in 20 cases. With good renal function the acid phosphatase concentration was highest within an hour after massage, occasionally elevated for about five hours, and at or slightly below the original estimate in twenty-four hours. When kidneys are impaired the rise may persist for two days.

J. Urol. 62:488-491, 1949.

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BACILLARY URINARY INFECTIONS are usually suppressed or reduced by Chloromycetin. From 1 to 1.5 gm. per day is given in divided doses of 0.25 to 0.5 gm. at intervals of six to eight hours. With severe involvement, the first dose is 1 gm. Since coccal organisms are often present, penicillin, sulfonamide, or both may be required. George E. Chittenden, M.D., and associates of Charles Godwin Jennings Hospital, Detroit, treated 50 patients with Chloromycetin, for most of whom other antibiotics had been unsuccessful. The majority of patients had calculi, enlarged prostate, or other lesions. Symptoms disappeared in 82% of cases and urine became sterile in 38%. The only toxic reaction observed from the antibiotic was slight vertigo in 1 instance.

J. Urol. 62:771-790, 1949.

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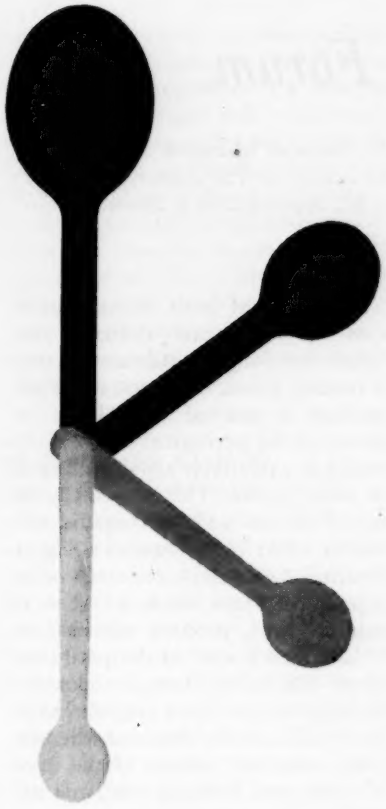

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Medical Forum

Discussion of articles published in MODERN MEDICINE *is always welcome. Address all communications to The Editors of* MODERN MEDICINE, *84 South 10th St., Minneapolis 3, Minn.*

Abdominal Paracentesis*

TO THE EDITORS: The continuous paracentesis by the electrosurgical method of Dr. William James Moore is novel and interesting. He has indicated that the advantages of his technic are prolonged drainage and less risk of wound complications. Critical evaluation of this procedure should be reserved if one has not had actual experience in its use. However, there seem to be some disadvantages in his method which should be mentioned.

Insertion of the electrocoagulating trocar leaves a zone of necrotic tissue through all layers of the abdominal wall. Charred, devitalized tissue is an inviting culture medium for bacterial invasion, either from within or without the abdomen. After the slough of electrocoagulation has been discharged or absorbed, the burned tissue tends to heal slowly with thick scar formation.

For those less skilled than Dr. Moore, caution should be taken not to damage intestine with the electrocoagulating trocar as it is being inserted. If the thin intestinal wall contacts the active electrode a fatal peritonitis might result from leakage at the site of injury.

Experience in the surgical research laboratory and with clinical problems of abdominal drainage has shown that organic substances, such as rubber, gauze, or plastic materials, produce a marked fibroplastic response in the peritoneal cavity which results in a relatively rapid walling-off of such drains. This interdicts the use of drains made of organic substances when continuous drainage is required. Conversely, materials of inorganic structure, such as glass or stainless steel, produce minimal reaction when placed in the peritoneal cavity. Efficient prolonged abdominal drainage by gravity or suction can be more satisfactorily obtained when the intraabdominal portion of the drain is constructed from an inorganic substance.

DANIEL J. PRESTON, M.D.
Wilmington

► TO THE EDITORS: There is no doubt that the many problems associated with abdominal paracentesis are so distressing that any contribution to the eradication of these problems is well received.

As for the advantages of the electrosurgical technic, I see but two assets. These are the prevention of implanting malignant cells in the wound and, secondly, the sterilization

*MODERN MEDICINE, Nov. 1, 1949, p. 58.

of the tract without the dissemination of pathogenic bacteria. Dr. William James Moore maintains that tuberculosis may be treated well by this method. Tuberculous peritonitis often responds simply to pneumoperitoneum following the routine type of paracentesis. Apparently the author's method does not allow air to enter the peritoneal cavity. Thus a beneficial introduction of air is not possible in tuberculous ascites.

BERNARD J. FICARRA, M.D.

Brooklyn

Temperature Cycle in Obstetrics and Gynecology*

TO THE EDITORS: Dr. Melvin B. Sinykin has presented an excellent résumé of the relationship between ovulation and rise in basal temperature of the body.

As he points out, the body temperature in most menstruating women follows a cyclic pattern and the temperature curve often reflects certain phases of the menstrual cycle. Such cyclic variations are not seen in women who are not truly menstruating, that is, who are not ovulating. However, as in all matters in medicine, the rule does not always hold and these cyclic variations are not always clear, even in ovulating women.

For women who can practice rhythm contraception, basal temperature makes an excellent guide. However, every woman cannot follow this method; some conceive even when intercourse takes place only during menstruation, although such conception would seem impossible in view of our present beliefs on the time of ovulation and the length of life of the spermatozoon.

P. A. MC LEOD, M.D.

Kingston, Ont.

*MODERN MEDICINE, Apr. 1, 1949, p. 64.

Amyotrophic Lateral Sclerosis

TO THE EDITORS: As a result of the publication of my statement in your Medical Forum that adrenal cortex therapy appeared to influence favorably the course of amyotrophic lateral sclerosis (*Modern Medicine*, July 15, 1949, p. 72), I have had numerous written requests for details and, more recently, privately communicated confirmation of the myodynamic "lift" afforded some patients. I also mentioned a more insensible sustaining effect which I believed to become overt only after prolonged therapy.

I am impelled to elaborate somewhat on my present treatment schedule at this time, first, because the written requests have been for further information and, second, because a definitive paper, now in preparation, will probably not see publication for many months. There is the further impetus of a very recent verbal report at a Chicago Symposium that amyotrophic lateral sclerosis was one of the diseases *not* favorably influenced by the administration of adrenocorticotropic hormone, ACTH.

In view of my own present conviction that adrenocortical therapy justifies its onerous expense to patients with this disease, I am anxious that the single report of the failure of adrenocorticotropic therapy be not misconstrued. There may be a difference and an explanation of the difference.

With regard to my treatment schedule, it consists of the individualized administration of from 3 to 15 cc. of whole cortex extract (aqueous) daily, or in divided doses twice daily. The dose which reduces fasciculations, spasticity, and ankle clonus to minimums is found and continued indefinitely.

Occasional trials at dosage reduction were not well borne by my patients, but they responded anew to resumption of full dosage. These trials had been instituted to alleviate possible pituitary adrenocorticotropic depression; they inevitably led to a degree of relapse that made apparent, by contrast, the previous gradual improvement of the patients during periods of relentless cortical extract administration. I no longer worry about the pituitary, and though I continue B_{12}, a high-fat diet, testosterone, and progesterone (in some instances) as a matter of orthodoxy, I am reasonably sure that adrenal cortex is the prime factor in causing the arrest.

Evaluation of results should be made only after some months of continued therapy. In such an evaluation, no reasonable person would anticipate any extensive restitution of function of markedly demyelinated tracts. Any mode of treatment must be evaluated in light of the physiologic dogma that there can be no regeneration, anatomically, within the central nervous system proper. Longstanding cases of amyotrophic lateral sclerosis are poor objects for reexamination of the facets of this dogma, but I have seen indubitable evidence of definite, if minimal, return of volitional activity to certain long-dormant muscle groups.

Amyotrophic lateral sclerosis is probably an atopic response to allergenic cholinergesis, with or without psychogenic cholinergesis, in which the pyramidal pathways and their connections react as the atopic shock organ. As in all atopic reactions, two independent modalities of compensation are called into play. One is the Selye corticotropic-cortical "alarm" mechanism and the other is the erythropoietic cholinesterase mechanism.

The latter modality alone fails in such a condition as acute leukemia, which is also the result of an atopic reaction. Both modalities may fail in irreversible surgical shock. In amyotrophic lateral sclerosis there is usually enhanced erythropoiesis and an elevated blood cholinesterase so that, on this premise, compensation failure must lie in the corticotropic-corticosteroid mechanism. Extension of the premise furnishes the rationale of adrenal cortex therapy.

ROBERT D. BARNARD, M.D.
New York City

Diet in Diabetes*

TO THE EDITORS: Dr. Lester J. Palmer presents a dietetic regimen for the diabetic, with a sample menu containing carbohydrate 165, protein 80, and fat 90 gm. His views are in agreement with the majority of authoritative opinions—although there are notable dissenters.

It has been the custom to provide 1 gm. of protein per kilogram of body weight. There is increasing evidence that adequate stores of body

*MODERN MEDICINE, June 1, 1949, p. 57.

protein are helpful in resisting infection and in prevention of fatty livers and, possibly, of retinitis. Even higher values than the increased protein allowance suggested by Dr. Palmer are therefore advocated by some authorities.

The optimum carbohydrate in the diet is still a subject of debate, ranging from the unlimited choice of the "free-dieters" to that of strict limitation. Diets containing 150 to 200 gm. are most popular. Smaller amounts are disliked by patients, while higher starch values make attainment of near normal blood sugars more difficult. The desirability of the latter objective in itself has been much debated.

Recent experimental evidence appears to support the view that hyperglycemia is damaging to the pancreas. However, the ideal of maintaining rigid control of blood sugar levels will in many cases evoke hypoglycemic reactions. The damage which these reactions are believed to cause to the central nervous system would outweigh any benefits gained by sparing the pancreas.

Having provided for the protein and carbohydrate intake, the remaining calories required will be made up of fat. However, there are some who believe that fat should be fixed at a low level, with consequent increase in carbohydrate, on the theory that the incidence of hypercholesterolemia and atherosclerosis can be reduced thereby. These diets are somewhat unpalatable and it is also possible that deficiency in essential food factors may occur. Moderate fat allowance, such as recommended by Dr. Palmer, is therefore most commonly in use. The problem of the relation of diet to arteriosclerosis is not yet settled, and an open mind should be maintained on this question.

B. H. LYONS, M.D.

Winnipeg

► TO THE EDITORS: The diet presented by Dr. Lester J. Palmer is for the uncomplicated diabetic. It is liberal with respect to carbohydrates and protein. It contains more fat than the high-carbohydrate low-calorie diet, but this circumstance is, to some extent, counterbalanced by the fact that the caloric content is regulated by the energy requirements of the individual.

Dr. Palmer also stresses *variety* of food materials. The diet thus meets the vitamin and mineral requirements without subjecting the diabetic to the inconvenience and expense of special preparations of these essential food elements. The diet, therefore, conforms to well-established physiologic principles. Conforming also to well-established practice is the insistence upon sugar-free urine and a blood sugar level approximating normal.

Compared with this method of treatment is the increasing use of the "free" diet combined with insulin, with little or no attention to blood and urine sugar—a practice which is not only uneconomical but inevitably harmful if continued for long. With the free diet, not only do many more diabetics require insulin than with a diet such as Dr. Palmer's, but the average dose is appreciably larger.

Clinical experiences and animal experimentation also clearly show that persistent hyperglycemia, which is almost inevitable with the free diet, results in deterioration of the islands of Langerhans and also of the liver, as shown by liver function tests, enlargement of the liver in children, and fatty infiltration at autopsies. Dr. Palmer's criteria of the control of diabetes are therefore particularly gratifying.

An additional consideration with the free diet is that the increasing diabetic population will inevitably aggravate the problem of insulin supply, unless, in the meantime, new sources of insulin are discovered.

I. M. RABINOWITCH, M.D.

Montreal

Culdoscope in Gynecology

TO THE EDITORS: I feel that Drs. Richard B. Dunn and Donald C. Schweizer have covered the subject of the culdoscope very well and that this method of diagnosis has a very definite place as a diagnostic procedure in gynecology. I have been interested in the use of the culdoscope ever since Dr. Decker first described its use. Through his efforts in the utilization of the knee-chest position he has made peritoneoscopy a valuable diagnostic adjunct.

We have not considered general anesthesia necessary for culdoscopic examinations and have done many satisfactorily by the local injection of 1% novocain into the vagina after the patient has been well sedated. However, lately, we have resorted to the use of saddle-block type of anesthesia with excellent anesthetic effect. There is definitely more difficulty in having the patient retain the knee-chest position when saddle-block is used than when local anesthesia is given.

This culdoscopic procedure has a definite place in obviating many laparotomies that are done simply for exploratory reasons. The surgical risk with culdoscopy is much less than with laparotomy. The entire pelvis can be viewed quite satisfactorily and pathologic processes diagnosed, with sufficient training.

As the authors state, this procedure is also very valuable in the diagnosis of sterility, inasmuch as the patency of the tubes can be discerned by direct vision when the culdoscopy is done.

The contraindications of this procedure are few: any fixed mass in the cul-de-sac, and cardiac conditions that preclude the patient's assuming the knee-chest position.

HARLEY E. ANDERSON, M.D.

Omaha

► TO THE EDITORS: We have been using the culdoscope as a diagnostic aid for several years and think it is a great help in many cases.

We have made a light, wooden, padded board shaped like an inverted "U," which rests on the operating table to hold the patient in knee-chest position during the procedure. It has been a great asset, especially if the patient has received pentothal.

Our main difficulties with the procedure occur when adhesions obscure the field or with an adherent retroverted uterus.

WILLIAM BUSTER MC GEE, M.D.

San Diego

*MODERN MEDICINE, Jan. 1, 1950, p. 67.

What Can Be Done for the Hay Fever Patient?*

TO THE EDITORS: The excellent paper by Dr. Albert V. Stoesser refers especially to the treatment of hay fever in children, but most of the statements made are equally applicable to adults.

I heartily agree with the author that hay fever patients should be regarded as perennial problems. If we could persuade the patient that his treatment is a matter of years instead of the particular year in which he consults the physician, the results would be very much more satisfactory.

I was pleased to see that the use of drops in the nose was not advocated except for a very short period of time. Much harm has been done by instillation treatment.

The author's comments on antihistamine therapy are quite helpful and the classification of the various antihistaminic drugs is clarifying.

Of course, the injection treatment of pollen extracts is rightly considered the most important part of the treatment. Careful reading of this section of the article is well worth while and I would especially emphasize the statement made that "approximately 60% of the failures were due to lack of cooperation on the part of the patient, the doctor's office, or both in following closely the dosage schedule, to absence of information concerning other allergies of the hay fever sufferer, and to full disregard of special rules of conduct during the hay fever season."

HERBERT K. DETWEILER, M.D.

Toronto

*MODERN MEDICINE, Aug. 1, 1949, p. 47.

► TO THE EDITORS: I was interested in reading Dr. Stoesser's article. Most of his hay fever cases have been in children and he has given an up-to-date review of the best methods of diagnosis and treatment.

As he points out, many of these children do not present the usual symptoms of rhinitis and corneal injection, but may have a continual irritating cough or a "summer cold" which lasts for some weeks or even a few months, then clears up suddenly when the pollen count drops. The symptoms will be repeated the next summer and this time the physician should realize that the inhalation of grass or ragweed pollen is the real cause of the patient's symptoms.

Dr. Stoesser rightly stresses the fact that while the newer antihistamine drugs have given temporary relief to many patients, they will not supplant the more reliable method of treating these patients by pollen injections. If the diagnosis is correctly made by skin tests, using the pollens or molds to which the patient is sensitive, and the patient is treated with these particular allergens, the results of treatment are usually very satisfactory, particularly if the patient is a child and has not had symptoms for more than a few years.

I do not altogether agree that the preseasonal method of treatment is preferable to the perennial method of giving doses of the specific pollen at long intervals throughout the year. We believe that a higher degree of desensitization may be achieved by this latter method.

J. R. ROSS, M.D.

Toronto

Diagnostix

Here are diagnostic challenges presented as they confront the ***consultant*** *from the first clue to the pathologic report. Diagnosis from the* ***Clue*** *requires unusual acumen and luck; from* ***Part II****, perspicacity; from* ***Part III, discernment.***

Case MM-162

THE CLUE

ATTENDING M.D: I remember your telling me not long ago that you were especially interested in hemolytic anemias.

VISITING M.D: Yes, and I still am.

ATTENDING M.D: Good. Then you'll want to see a two-year-old child that has just been admitted with

Lederer's anemia. We presented him at the last weekly clinic. He has been in the hospital only twelve hours and is receiving transfusions.

VISITING M.D: Lederer's anemia is one of an extremely interesting group of blood diseases—the so-called acute hemolytic anemias of unknown origin. The disease is usually attributed to infection, you know. Did the child have a febrile illness, leukocytosis, lethargy, and gastrointestinal symptoms?

ATTENDING M.D: Well, yes, lethargy and diarrhea and he is feverish. The leukocyte count is 20,200, with 60% neutrophils, 36% lymphocytes, and 4% eosinophils. Red cell count 2,000,000; hemoglobin 5 gm. per 100 cc., and hematocrit 20 volumes per cent. Smear showed anisocytosis, fragmentation, and polychromatophilia. Urine was port wine in color, and the benzidine test for hemoglobin was strongly positive.

VISITING M.D: What caused the anemia? How acute is the illness?

ATTENDING M.D: I do not know. The child was in good physical health until three days ago when he started passing six to eight loose stools a day and wine-colored urine. According to his parents, he had received no medication and had not been exposed to any poisons or chemicals.

PART II

VISITING M.D: Porphyrins negative? Other studies?

ATTENDING M.D: No porphyrins in the urine. The reticulocyte count is 8%. Sternal aspiration shows nothing diagnostic. Serologic test for syphilis not reported. No icterus.

VISITING M.D: Acute hemolytic anemia

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*Anderson, J. and Steele, C.: *Use of Nitrofuran Therapy in External Otitis,* Laryngoscope 58:1279, 1948 • Douglass, C.: *The Use of Furacin in the Treatment of Aural Infections,* Laryngoscope 58:1274, 1948 • Reardon, H.: *Unpublished results.*

and hemoglobinuria of unknown etiology. . . . Let me talk to the father and mother. *(A long interview ensues in the office, the consultant then comes out)* Let me see a sample of the stool and urine. *(Smells the specimens)* Send a specimen of urine to the toxicology department.

PART III

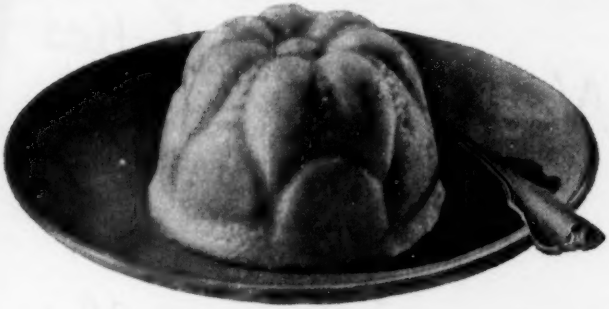
VISITING M.D: *(Examining patient)* Heart, lungs, abdomen negative. Fundus—roughly negative. Deep reflexes—normal, nothing objective except temperature of 100.2° rectally. The father told me that the boy had been chewing moth balls.

PART IV

ATTENDING M.D: *(Two days later)* The toxicologist reported that the first urine specimen contained naphthol; yesterday's contained only a trace; and today's, none.

VISITING M.D: The moth balls that the parents brought in contained naphthalene. Moth balls are far from harmless, yet children occasionally suck them. I have seen a similar case. Well, we've lost our case of Lederer's syndrome.

A Valuable Adjunct in INFANT and CHILD FEEDING



Unflavored Gelatine as an Aid to Nutrition and Digestion

The unique qualities of Knox Unflavored Gelatine make it especially useful in the dietary of infants and children.

In certain cases where difficulty is encountered in the digestion of a milk formula the addition of 2 percent of Knox Gelatine improves digestibility. It is also useful in increasing the protein content of the formula.

Older children benefit from the recognized nutritional benefits and added appetite appeal of gel-cookery dishes made with Knox. Unlike ready-flavored gelatin dessert powders with their high sugar and acid content, Knox is all protein with no sugar content.

FREE DIETARY GUIDE BOOK IN INFANT AND CHILD FEEDING

"*Knox Gelatine in Infant and Child Feeding*" contains detailed information compiled from experience, plus an assortment of carefully selected recipes. Copies are available to you upon request. Write Knox Gelatine, Dept. R-25, Johnstown, N. Y.

Available at grocery stores in convenient 4-envelope and 32-envelope packages.

three essentials...in the effective treatment of biliary dysfunction

are combined in Caroid and Bile Salts Tablets.

They afford a desirable threefold action as—

K
choleretic...to produce increased bile flow

Q
digestant...to assist digestion

J
laxative...to induce peristaltic action and help reestablish normal function.

Caroid and Bile Salts Tablets have been a prescription favorite for many years as an effective aid in the treatment of biliary stasis, cholecystitis, constipation of biliary origin. Available in bottles of 20, 50, 100, 500 and 1000.

tablets of... **Caroid and Bile Salts** with Phenolphthalein

American Ferment Company, inc. 1450 Broadway, New York 18, N.Y.

trial supply on request

Short Reports

THERAPY

Acute Gouty Arthritis

Colchicine administered with or shortly after ACTH apparently prevents recurrence of acute gouty arthritis. Although hormone treatment alone is effective in combating the disease, Dr. William Q. Wolfson and associates of Chicago find that the glycocorticoid deficiency after withdrawal of ACTH may precipitate a new attack. Addition of colchicine to ACTH dosage appears to overcome this tendency. No patient given the concurrent dosage has had even a minor recurrence of acute gouty arthritis within one month of therapy.

Proc. Central Soc. Clin. Research 22:93, 1949.

NEUROSURGERY

Operation for Tachycardia

After complete sympathetic motor denervation, resting pulse rates are slowed, particularly in a patient with rapid rates. This procedure may be effective in hypertensive individuals with unusual degrees of tachycardia. By removing the second to fifth thoracic sympathetic ganglia on both sides, Dr. R. H. Smithwick of Harvard University, Boston, and associates noted reduction of basal pulse, acceleration after exercise, and no untoward effects. A few instances of exertional, emotional, or paroxysmal auricular tachycardia were also controlled by sympathectomy.

Surgery 26:727-744, 1949.

ONCOLOGY

Lung Cancer and Cigarettes

Smoke from cigarettes may be one of the causes for primary bronchogenic carcinoma. The disease, which was infrequent fifty years ago, is now one of the most common types of cancer. The increased incidence, suggests Dr. Evarts A. Graham of Washington University, St. Louis, is therefore attributable to some factor associated with modern living. The following observations indicate cigarette smoking as the responsible agent: [1] Statistical curves are similar for the increase both of bronchogenic carcinoma and of cigarette sales. [2] Lung cancer is rare in a patient who is not, or has not been at some time, an excessive cigarette smoker. [3] More men than women are affected by the disease, perhaps because women of cancer age seldom use cigarettes excessively. Use of tobacco in pipes and cigars apparently does not have the same etiologic relationship. The carcinogenic agent in cigarettes may be some factor used in curing the tobacco or in the paper or insecticides employed during plant growth.

Inter-Am. Cong. Surg. 1949.

PERSONNEL

Hawley to ACS

Dr. Paul R. Hawley, who recently resigned as executive officer of the Blue Cross and Blue Shield Commissions, has become director of the American College of Surgeons.

NEUROLOGY

Epilepsy Sequela of Recurrent Malaria

Cerebral damage, manifested by convulsive seizures, may be caused by recurrent malaria. Since many soldiers discharged during World War II because of epilepsy were stationed in malarial areas when the seizures began, *Plasmodium* infection should be considered in the differential diagnosis of convulsive attacks, point out Dr. David R. Talbot and associates of Wadsworth General Hospital, Los Angeles. Electroencephalograms may prove useful in distinguishing the condition. If the epilepsy is a sequela of malaria, treatment of the malaria is of primary importance; anticonvulsive therapy is only secondary. Intensive malarial therapy may bring improvement before further damage appears.

J.A.M.A. 141:1130-1132, 1949.

"I must ask my patients to paint their house numbers on their roofs."

ORTHOPEDICS

Molded Plastic Splints

A light, waterproof, and durable adjustable splint can be made of Celastic, a napped cotton material impregnated with pyrorylin. The method described by Beatrice F. Schulz of Washington University, St. Louis, is simple and inexpensive. The splint is cut from Celastic after being traced from a paper pattern. In forming a splint of more than two layers, the innermost or first and second layers are dipped in solvent and removed as soon as moist. The two layers are then laid together on a glass or rubberized silk surface and laminated by hand or roller pressure. When the fabric is no longer sticky and is dry enough to hold a slight curve, the laminated layers are shaped around the part to be splinted. The splint should remain in place until the material has set well enough to hold the proper contour when removed. An old prosthetic or discarded plastic shell can be used for rough shaping if the patient is not present. The Celastic must then dry for another hour before the finishing compound can be applied. During this time reinforcement layers and strap loops are added. About five or six coats of finishing compound should be applied to the splint either by dipping or by painting. Reshaping is possible after any of the applications. Because of the drying action of the solvent on the skin, rubber gloves should be worn while handling the moist Celastic, and the part to be splinted should be wrapped in nonporous material for initial fitting.

Physical Therap. Rev. 29:543-546, 1949.

in choosing an oral xanthine preparation...

Check These Advantages

◉ Low tendency to gastric irritation ◉ Oral dosage can be pushed to full therapeutic effect with minimal risk of unpleasant reactions ◉ Stability ◉ Ready absorption—brings about rapid clinical effect

BRAND OF THEOPHYLLINE SODIUM GLYCINATE

Central

Raises the Xanthine Dosage Potential

The oral administration of aminophylline and other theophylline preparations has heretofore been limited by their tendency to cause gastric irritation. Often the limit of gastric tolerance has determined the dose employed.[1] Theophylline-sodium glycinate has the advantage of being "less irritating to the gastric mucosa. It is thus tolerated orally in larger doses than are possible with other theophylline preparations, and it can be administered by mouth in liquid form as well as non-enteric-coated tablet form."[2]

CHOOSE SYNOPHYLATE WHENEVER ORAL XANTHINES ARE INDICATED

SUPPLIED: ***Tablets*** — 0.33 Gm. and 0.165 Gm., each 0.33-Gm. tablet equivalent to 0.16 Gm. Theophylline U.S.P. Bottles of 100, 500, and 1,000. ***Syrup*** — Each teaspoonful (4 cc.) containing 0.33 Gm., equivalent to 0.16 Gm. Theophylline U.S.P. Bottles of 1 pt. and 1 gal. ***Suppositories*** (rectal) — Each suppository containing 0.78 Gm., equivalent to 0.39 Gm. Theophylline U.S.P Cartons of 12, foil wrapped.

1. Goodman, L., and Gilman, A.. The Pharmacological Basis of Therapeutics New York, The Macmillan Company, 1941; p. 281. 2. Council on Pharmacy and Chemistry, American Medical Association: New and Nonofficial Remedies, 1949. Philadelphia, J. B. Lippincott Company, 1949; p. 331.

THE CENTRAL PHARMACAL CO.
Products Born of Conscientious Research
SEYMOUR • INDIANA

MENTAL HYGIENE

Child Mental Health

Enough knowledge on mental health has been gathered in recent years to permit a program of child care based on scientific principles. A national plan patterned after the one already in effect in Rochester, Minn., is suggested by Dr. Henry M. Helmholz of the Mayo Clinic. The mental health experiment has been carried out for five years in the child health clinics of that city, which are used by virtually the entire population. Every child in the community is given a mental and emotional development test at the age of two-and-a-half years. When children's emotional disturbances are detected early enough, the large majority can be prevented from becoming personality difficulties. To make such a program effective, family physicians and school teachers as well as parents must learn the fundamentals of mental health.

PUBLIC HEALTH

Red Cross Blood Centers

Thirty regional blood centers are now in operation in the United States, supplying blood for 1,550 hospitals in thirty-four states. Since the early part of 1948, the National Blood Program of the American Red Cross has provided more than 500,000 pints of blood for medical use. Taken from voluntary donors, the blood is furnished by the Red Cross centers to physicians and hospitals without charge. In addition to whole blood and plasma, valuable derivatives are distributed. The most important of these is immune serum globulin used as an immunizing or modifying agent in measles. During the past year, the Red Cross distributed enough globulin for every case of measles reported in the United States. The derivatives were processed from surplus plasma returned by the Armed Forces after the last war. In another year, this supply will be depleted and globulin will have to be derived from blood received at regional centers.

CARDIOLOGY

Chemical Pharmacology Section

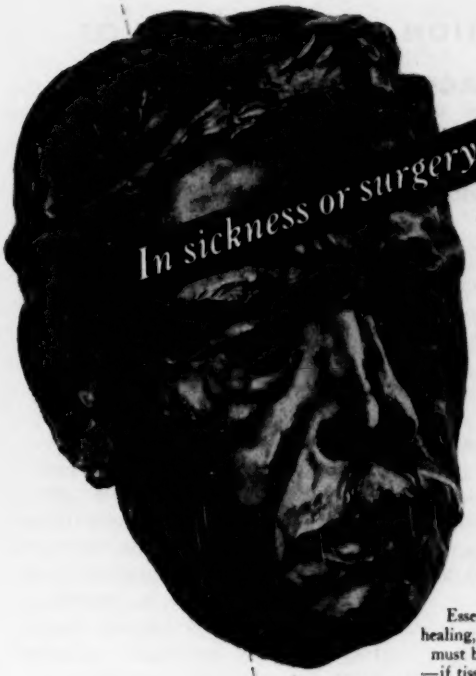
The National Heart Institute has established a chemical pharmacology section under the direction of Dr. Bernard B. Brodie of New York University, New York City. Dr. Sidney Udenfriend of Washington University, St. Louis, will head the units within the section.

CARDIOVASCULAR

Essential Hypertension

Veriloid is one of the most satisfactory of the extracts of *Veratrum viride* for treating patients with hypertension. Hypotensive action is similar to that of other *Veratrum* preparations and toxic effects fewer. The preparation can be administered for periods as long as five months. Dr. Robert W. Wilkins and associates of Boston University carefully adjust the dosage to the individual patient, increasing the amount slowly if necessary to lower the blood pressure, or decreasing the amount if the patient vomits or is nauseated. The initial dose, about 1 mg. of Veriloid four times a day after meals and at bedtime, may be slowly increased to about 2 mg. in three or four weeks.

Proc. Soc. Exper. Biol. & Med. 72:302-304, 1949.



In sickness or surgery, play safer with . . .

"Saturation Dosage"

of vitamins b *and* c

Depletion of the critical water-soluble B complex and C vitamins occurs so commonly in the presence of physical pathology, as to make a presumption of nutritive impairment[2] almost axiomatic. Essential to normal cell metabolism and wound healing, these poorly-stored, readily-diffusible factors must be replenished — usually by *massive dosage* —if tissue rehabilitation[3] and return to health[4] are to be expedited. • Allbee with C 'Robins' provides this all-important "saturation dosage" in convenient capsule form. It incorporates the important B factors in 2 to 15 times daily requirements, plus 250 mg. of vitamin C — *the highest strength of ascorbic acid available today in a multi-vitamin capsule.* • Its prescription represents a sound contribution toward decisive recovery from disease, or toward pre- and post-operative nutritional support.[1]

A. H. ROBINS CO., INC. · RICHMOND 20, VA.
Ethical Pharmaceuticals of Merit since 1878

FORMULA: *Each Allbee with C capsule contains:*

Thiamine hydrochloride (B_1)	15 mg.
Riboflavin (B_2)	10 mg.
Nicotinamide	50 mg.
Calcium pantothenate	10 mg.
Ascorbic acid (C)	250 mg.

REFERENCES: 1. Coller, F. A. and DeWeese, M. S.: Preoperative and Postoperative Care, J.A.M.A., 141:641, 1949. 2. Jolliffe, N. and Smith, J. J.: Med. Clin. North America, 27:567, 1943. 3. Kruse, H. D.: Proc. Conf. Convalescent Care, New York Acad. Med., 1940.
4. Spies, T. D.: Med. Clin. North America, 27:273, 1943.

allbee® WITH C

Robins

An Important Advance

IN THE PREVENTION AND TREATMENT OF IMPETIGO, EXCORIATED BUTTOCKS, MILIARIA, DIAPER RASH

—New Formula Johnson's Baby Lotion

For more than 3 years, the Medical Research Laboratory of Johnson & Johnson in co-operation with several leading universities, has been engaged in fundamental research leading to the development of a physiologically acceptable preparation for use on infant's skin. These efforts have culminated in the release of the new Johnson's Baby Lotion following an accumulated experience of over 10,000 baby days.

The findings indicate that the new Johnson's Baby Lotion is a specific preventative and therapeutic agent for the five most common skin afflictions of infancy: impetigo contagiosa, miliaria rubra, intertrigo, excoriated buttocks, and diaper rash.

Description and Pharmacologic Action

Johnson's Baby Lotion consists of a nontoxic, nonirritating oil-in-water emulsion, which, when placed upon the skin, produces a discontinuous film having the ability to protect the skin from external irritative agents, but without interference with the transpiration of water vapor and other physiologic functions of the skin.

Johnson's Baby Lotion, by virtue of its bacteriostatic and bactericidal properties, produces a marked and prolonged suppression of the resident bacterial flora of the skin, thus offering a substantial degree of protection against superficial infection.

Clinical Evidence

In 8 large hospitals, under the guidance of pediatricians and dermatologists, clinical investigations have been conducted on the new Johnson's Baby Lotion containing hexachlorophene* in a concentration of 1% as an antiseptic agent. Herewith are pertinent excerpts from the reports. (Complete reports available on request.)

(*Hexachlorophene has been adopted by the Council on Pharmacy and Chemistry of the American Medical Association as the generic designation of Dihydroxy-hexachlorodiphenyl Methane.)

In a Pennsylvania Hospital: "Conclusive evidence has been obtained that the hexachlorophene lotion is less irritating than ammoniated mercury, commonly used in newborn nurseries, and is more effective in preventing the minor skin irritations and superficial infections common to the newborn."

In another Pennsylvania hospital: "In the height of an epidemic of impetigo the hexachlorophene lotion not only prevented babies from developing lesions, but on

those babies who were affected, the lesions were few, discrete, and disappeared quickly without any other therapy. The epidemic of impetigo, which had been continuing for four months, ceased within a period of a week to ten days after the lotion was used on all babies in the nursery.

"It was concluded that the lotion exhibited an antibacterial effect which was sufficient to modify remarkably the course of a virulent epidemic of impetigo contagiosa."

In a New York State Hospital: "The hexachlorophene lotion was found to be unusually satisfactory in the routine care of the skin of infants beyond the newborn period and to be prophylactically effective in minimizing the incidence of diaper rash and miliaria."

In a Nebraska Hospital: "We saw no evidence of irritation from Johnson's Baby Lotion either in the babies on whom the lotion was applied or among the nurses applying the Lotion. We did not see at any time during our work any sensitivity to Johnson's Baby Lotion and on some of our children the Lotion has been applied at various times for a period of four months."

Summary

Clinical evidence indicates that the new formula of Johnson's Baby Lotion, containing hexachlorophene, is outstandingly effective in the prevention and cure of the major skin afflictions of infancy: impetigo contagiosa, miliaria rubra, intertrigo, excoriated buttocks, and diaper rash. Free samples of Johnson's Baby Lotion are available for your examination and for distribution to patients.

"Needless to say, you know how women are."

OPHTHALMOLOGY

Radiation Cataracts

Ocular defects have been noted in persons exposed to either atom bomb or laboratory radiation. The cyclotron-induced cataracts are probably the result of chronic exposure to neutron irradiation, believe Drs. P. H. Abelson of Carnegie Institution of Washington, D.C., and P. G. Kruger of University of Illinois, Urbana, since gamma-ray intensity is not high enough to cause cataracts. In a study of these defects in survivors of Hiroshima and Nagasaki, however, Dr. David G. Cogan of Harvard University, Boston, and associates of the University of California, San Francisco, were unable to determine the exact role played by either neutrons or gamma rays, both of which were present in the zone. Of the 10 scientists with ocular defects after exposure to laboratory radiation, only 3 suffered severe visual damage. The others had insignificant to moderate changes with little or no loss of sight. Blood of most of the 10 had been examined periodically while working in high-voltage laboratories, but no blood changes were observed. The estimated exposure of the scientists was surprisingly low, from 10 to 135 n with a median of 50 n.

Science 110:654-657, 1949.

HORMONES

Eosinophil Response to ACTH Therapy

Eosinophils completely disappear from the peripheral circulation of patients given intramuscular adrenocorticotropic hormones. No eosinophils were found in the blood of 10 patients six to seventy-two hours after start of ACTH administration, although counts had averaged 472 cells before therapy. Dr. Theron G. Randolph and associates of Chicago report that eosinophils return to pretreatment levels three to six days after cessation of therapy.

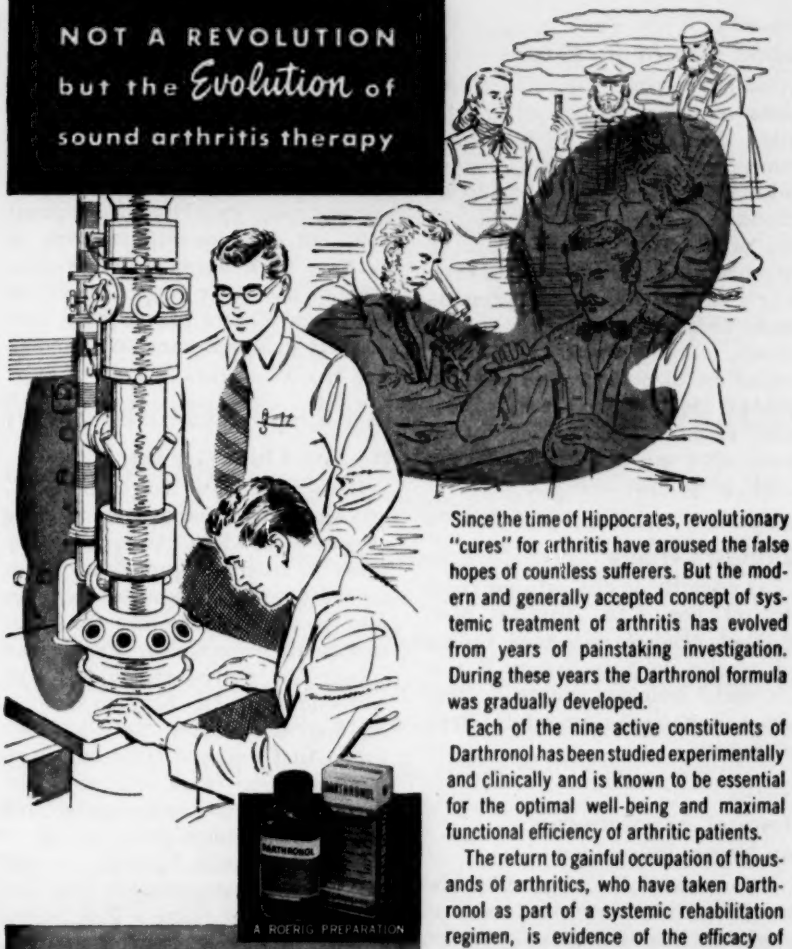
Proc. Central Soc. Clin. Research 22:67-68, 1949.

STATISTICS

Surgery in the U.S.

General practitioners and nonsurgical specialists perform about four times as much of the surgery as the surgeons do. Of the 10,000,000 operations performed in the United States during 1949, the market research department of MODERN MEDICINE finds that general practitioners did about 45%, while specialists in surgery did less than half this amount. About one-fifth of all surgical operations are done outside the hospital—in the doctor's office, the patient's home, or elsewhere.

NOT A REVOLUTION but the *Evolution* of sound arthritis therapy



A ROERIG PREPARATION

EACH CAPSULE CONTAINS:

Vitamin D (Irradiated Ergosterol)	50,000 U.S.P. Units
Vitamin A (Fish-Liver Oil)	5,000 U.S.P. Units
Vitamin C (Ascorbic Acid)	75 mg.
Vitamin B_1 (Thiamine Hydrochloride)	3 mg.
Vitamin B_2 (Riboflavin)	2 mg.
Vitamin B_6 (Pyridoxine Hydrochloride)	0.3 mg.
Nicotinamide	15 mg.
Calcium Pantothenate	1 mg.
d-alpha Tocopheryl Acetate	7.4 mg.

(Equivalent by biological assay to 3.3 mg. International Standard Vitamin E)

Since the time of Hippocrates, revolutionary "cures" for arthritis have aroused the false hopes of countless sufferers. But the modern and generally accepted concept of systemic treatment of arthritis has evolved from years of painstaking investigation. During these years the Darthronol formula was gradually developed.

Each of the nine active constituents of Darthronol has been studied experimentally and clinically and is known to be essential for the optimal well-being and maximal functional efficiency of arthritic patients.

The return to gainful occupation of thousands of arthritics, who have taken Darthronol as part of a systemic rehabilitation regimen, is evidence of the efficacy of Darthronol in abolishing pain, diminishing soft tissue swelling and restoring useful function.

DARTHRONOL

FOR THE ARTHRITIC

J. B. ROERIG AND COMPANY
535 Lake Shore Drive, Chicago 11, Ill.

ONCOLOGY

Cancer Caused by Plastics

Cellophane and polyethylene implants may cause malignant growths within the body. Dr. B. S. Oppenheimer and associates of Columbia University, New York City, find that cellophane wrapped around the kidneys of white rats or embedded in the abdominal wall induces cancer in 35% of the animals. Such tumors, mostly fibrosarcomas, appear spontaneously in only about 1% of rats. Similar use of polyethylene produces sarcomas in more than 11% of animals. Cancers have not been observed after use of these plastic materials in human beings.

AWARDS

Chemistry Honor

For research on the calcium chemistry of bone, Dr. Pauline Berry Mack of Pennsylvania State College will receive the 1950 Francis P. Garvan Medal honoring women in chemistry, announces the American Chemical Society.

HOSPITALS

Hospital Appointments for Negro Physicians

The status of the Negro physician in New York City has improved within the past few years, according to an editorial in *New York Medicine*. In 1944, Dr. Conrad Berens, president of the Medical Society of the County of New York, took a firm stand for admission of Negro students to medical colleges, for acceptance of Negro physicians as members of hospital staffs, and against discrimination in admission to or certification by national medical or surgical organizations. Since that time, advances have been made. The American College of Surgeons which had only 1 Negro member in 1944 now has more than 20. A negro has been elected to the House of Delegates of the American Medical Association, and 170 Negro physicians hold 258 different appointments in 32 New York hospitals. More than 90% of the city's Negro physicians under forty years of age now have hospital staff appointments.

New York Med. 5:13-14, 1949.

NUTRITION

B_{12} and Child Growth

Daily oral doses of vitamin B_{12} are apparently effective in fostering growth of children. Although recognized as a growth-promoting agent for bacteria and animals, the vitamin has been used in man chiefly for treatment of pernicious anemia and sprue. The nutritional value of B_{12} was studied by Dr. Norman C. Wetzel and associates at the Children's Fresh Air Camp and Hospital, Cleveland. A group of 11 children under regular care for malnutrition and slow growth were given 10 μg of crystalline vitamin B_{12} orally in addition to whatever treatment they were having at the time. This single change in routine brought dramatic results for 5 of the children. Not only were their growth rates accelerated, but physical vigor, mental attitude, and appetite improved. The most striking results were obtained for a boy with allergic bronchitis. Besides growth improvement his asthmatic symptoms disappeared in the first week of B_{12} therapy.

Science 110:651-653, 1949.

for emotional equilibrium in the menopause

BENZEBAR* not only frequently alleviates the depression you see in menopausal patients, but also the nervousness.

'BENZEBAR' is a logical combination of Benzedrine* Sulfate (racemic amphetamine sulfate, S.K.F.) and phenobarbital. Thus, it provides the unique improvement of mood characteristic of 'Benzedrine' Sulfate and the mild sedation of phenobarbital. These two established agents work together to stabilize the patient's emotions and to restore her zest for life and living. ***Smith, Kline & French Laboratories, Philadelphia***

Benzebar

for the depressed

and nervous patient

*'Benzedrine' and 'Benzebar' T.M. Reg. U.S. Pat. Off.

NOW AVAILABLE..

BALANCED HORMONE THERAPY

DI-STEROID

TRADEMARK

BRAND OF ESTROGENIC SUBSTANCE AND TESTOSTERONE

Kremers • Urban

IN DIPHASOL

Estrogen plus Androgen in a Single Injection For Dual Pituitary Inhibition

In several conditions in the female in which estrogens and androgens are useful separately, the mechanism of action appears to be inhibition of the pituitary; **DI-STEROID*** supplies the synergistic pituitary-inhibiting action of *both* hormones, thus permitting smaller doses of each and reducing the risk of side-effects.

FEATURES

• Avoids masculinizing effects • Obviates disagreeable hyperestrogenic effects (breast and pelvis tenderness and withdrawal bleeding) • Valuable in conditions requiring treatment over relatively long periods • In DIPHASOL solution—provides the steroids for both immediate and prolonged effects.

INDICATIONS: Menopausal syndrome; suppression of lactation and painful breast engorgement post partum; mastopathies; menometrorrhagia; and dysmenorrhea.

SUPPLIED: 10-cc. multiple-dose vials; 1-cc. ampuls, boxes of 6 and 25.

Kremers • Urban Company

PHARMACEUTICAL CHEMISTS SINCE 1894

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UNIQUE INJECTION SOLVENT...

DIPHASOL

PATENT PENDING

DIPHASIC VEHICLE

Kremers • Urban

Permitting Immediate and Prolonged Hormonal Effect

DIPHASOL solutions of hormones are clear, non-oily . . . no crystals to clog the needle.

DIPHASOL solutions replace conventional suspensions of hormones. Microcrystals are deposited in the muscle fibres *only after dilution in situ by the tissue fluids.*

HOW IT WORKS: Upon injection of a **DIPHASOL** solution of steroids, part of the solution passes immediately into the lymphatic circulation for *rapid* hormone effect; the remainder, when diluted by the tissue fluids, deposits microcrystals which are absorbed more slowly, for *prolonged* effect.

Kremers-Urban specialties available in **DIPHASOL** solution include ESTRUGENONE,*. PROSTRUGEN,* DI-STEROID,* DI-STERONE* (testosterone and estrogens, testosterone predominating), DI-ERONE* (testosterone and progesterone), testosterone, and progesterone.

DIPHASOL contains propylene glycol, ethyl alcohol, isotonic solution of sodium chloride, and benzyl alcohol.

1. Inject with a 26-gauge needle. 2. Gives prompt and prolonged effect. 3. Clean syringes with water.

*Trademark of Kremers-Urban Co.

BOX 2038 • MILWAUKEE 1, WISCONSIN

METABOLISM

Parenteral Nutrition

Intravenous administration of a 15% emulsion of fat may prevent weight loss and help maintain a positive nitrogen and potassium balance when illness impedes adequate nutrition. The emulsion, consisting of 15% coconut oil, 4.3% dextrose, and a combination of 0.5% soybean phosphatides and 1% polyglycerol esters, is administered at rates used for glucose and saline solutions and supplies 1,600 calories per liter. Daily amounts of 3 and 6 gm. of fat per kilogram of body weight administered to adults and infants, respectively, maintain weight and positive nitrogen and potassium balance. In 3 patients, Dr. Sherwood W. Gorens and associates of Harvard University, Boston, found that amounts ranging from 0.8 to 4 gm. of fat per kilogram of body weight caused a rise of 1 to 3 degrees in temperature. Other patients received the same amounts or more, however, with no such effect. Pyrogenic materials in the fat rather than the fat itself were probably responsible. The emulsions do not appear to cause pathologic change.

J. Lab. & Clin. Med. 34:1627-1633, 1949.

ENDOCRINOLOGY

Cortisone in Male Urine

The compound 17-hydroxy 11-dehydro corticosterone can be isolated from the urine of normal males. Dr. John J. Schneider of Jefferson Medical College, Philadelphia, finds that the material, cortisone, can be procured from a chloroform extract of pooled normal human urine obtained before hydrolysis.

Science 111:61, 1950.

"It may look like 'A' to you but I calls 'em as I sees 'em!"

VITAMINS

Lipotropic Effect of B_{12}

When given to rats in conjunction with a high-fat diet, vitamin B_{12} concentrate has a lipotropic effect similar to that of liver extract. After twenty-nine days, Drs. Victor A. Drill and Harry M. McCormick of Wayne University, Detroit, found that the average fat content of livers of animals given 0.2 μg of vitamin B_{12} three times a week was only about 16%. When the vitamin was withheld, the fat content was nearly twice as much. The treated animals also gained more weight than untreated rats on the same diet. When 1 μg was given, the amount of liver fat was approximately the same as in rats fed a normal diet. The exact nature of the lipotropic effect of vitamin B_{12} is not known. The concentrate contains insufficient choline for that element to be responsible.

Proc. Soc. Exper. Biol. & Med. 72:388-390, 1949.

PROTAMIDE

FOR THE LANCINATING PAINS AND ANESTHESIA OF

TABES DORSALIS

A DRAMATIC THERAPY CLINICALLY PROVED FOR THE RELIEF OF PAIN AND LESIONS OF HERPES ZOSTER

AVAILABLE IN 10 AMPUL 1.3 cc SIZE. PHYSICIAN'S PRICE $15.00

DESCRIPTION: An aqueous, colloidal solution of a proteolytic enzyme, processed by the original method discovered and developed by Fuller. Each lot is clinically assayed for efficacy.

INDICATIONS: Critical evaluation by competent investigators has firmly established Protamide as the therapy of choice for herpes zoster and tabes dorsalis.

ADMINISTRATION: Freedom from side effects and comparative absence of pain on intramuscular injection—adds to the acceptance of Protamide.

DOSAGE AND RESULTS: The pain of herpes zoster is often relieved after the first injection. However, an ampul daily for 3 to 4 days is recommended. Pain is controlled and lesions heal rapidly in the great majority of cases. Of 45 patients with tabes dorsalis receiving 12 ampuls or more of Protamide, 44 received relief from lightning pains.*

SEND FOR LITERATURE: Please write for literature and reprint . . . Protamide is available from your local supplier, or direct from us. Protamide is stable at room temperatures. Keep a package on hand . . . Gain experience with this valuable contribution to therapy.

***Extensive Clinical Data on Request.**

SHERMAN LABORATORIES
G. H. Sherman, M. D., Founder
BIOLOGICALS • PHARMACEUTICALS
DETROIT 15, MICHIGAN

REGISTERED U. S. TRADEMARK

CIRRHOSIS

Serum Lipids and Xanthomas

Occurrence of skin xanthomas with primary biliary cirrhosis seems to be directly related to the degree of elevation of the total serum lipids. When the elevation is above 2,000 mg. per cent for a prolonged period of time, Drs. Edward H. Ahrens, Jr., and Henry G. Kunkel of the Rockefeller Institute for Medical Research, New York City, find that skin xanthomas usually develop. If the biliary obstruction is relieved, the lipids fall and the xanthomas resolve. If the level does not exceed 1,800 mg. per cent, the patient will probably remain in the pre-xanthomatous phase of the disease. The lipid pattern of primary biliary cirrhosis comprises notable elevation of the phospholipids and lesser but significant increases of free cholesterol and neutral fat, with clear nonlipemic serum.

J. Clin. Investigation 28:1565-1574, 1949.

SURGERY

Portal Occlusion

Irritative cellophane may be useful in preparing the portal vein for ligation and in experimental study of decreased blood flow. The vein is encased in a double cuff of Polythene and the diameter is then tightened one-third to one-half by a narrow tantalum band. By this method, Drs. Peter W. Stone and Ralph A. Murphy, Jr., of Emory University, Atlanta, Ga., produced partial occlusion in dogs with development of adequate collateral circulation in five days and complete obliteration of the lumen in forty to sixty days.

Proc. Soc. Exper. Biol. & Med. 72:255-259, 1949.

PREVENTIVE MEDICINE

Fluorine-Goiter Relationship

The addition of fluorine to drinking water for the prevention of tooth decay may increase the incidence of goiter. Dr. D. G. Steyn of the University of Pretoria has found such a trend in several regions of South Africa where fluorine is being added. The material, which has chemical properties similar to those of iodine, is attracted to the thyroid and acts to deprive the gland of iodine. This action is intensified by water with a high-calcium content. Goiters may be prevented in persons drinking such water by a greater intake of iodine.

DIAGNOSIS

Neurogenic Appendicitis

Abdominal pain in the right lower quadrant, with nausea, vomiting, and possibly fever, may be due to a tumor-like growth of nerve fibers and ganglion cells in the appendix. In 536 vermiform processes examined by Gustav Lassmann, M.D., of Vienna, 91 cases of appendicular neuromas were found. Pathologic findings were limited to the nerve endings. Secondary inflammation was found in only 5 of the 91 cases. Postoperative observation of 16 patients revealed that 6 were not relieved by surgery. The appendix should be removed early, while the process is still localized.

Mikroskopie 4, 9/10:277-290, 1949.

WHO

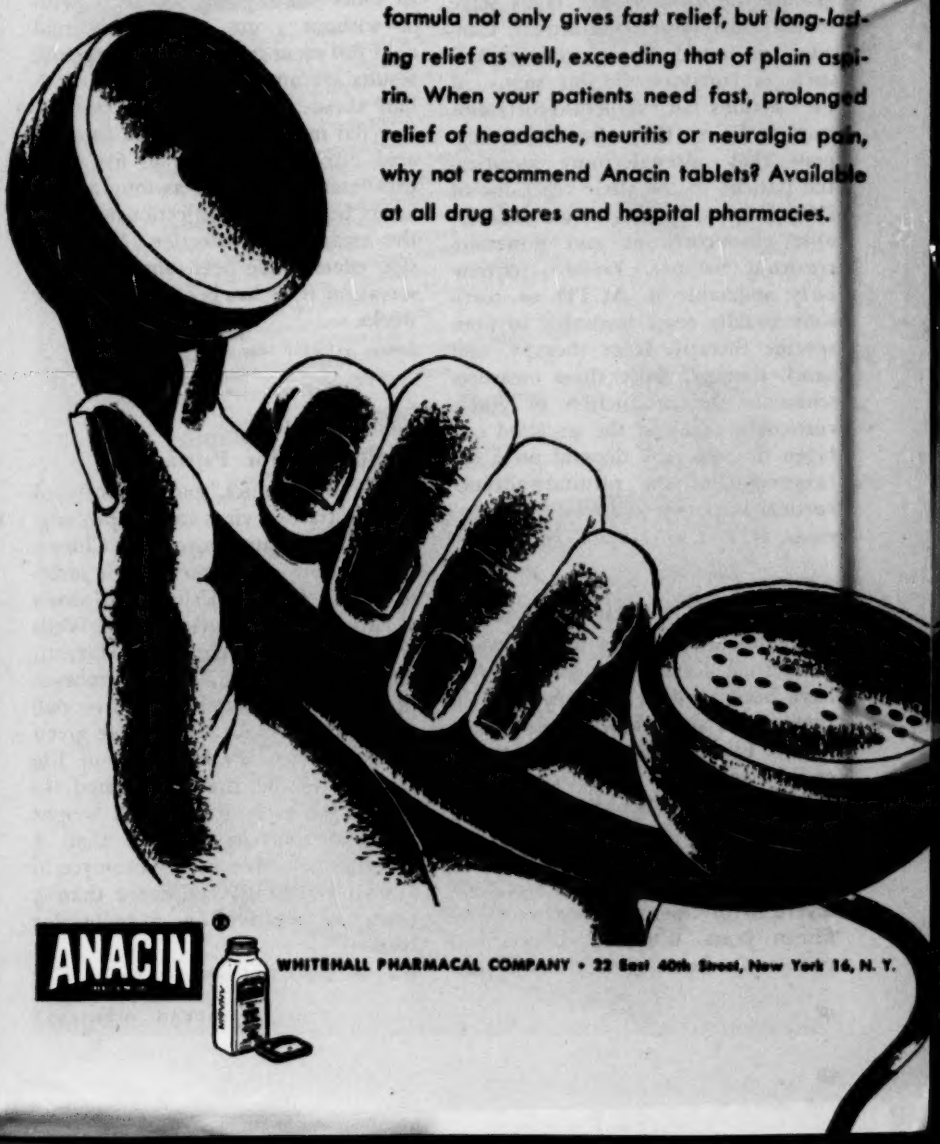
World Health

Peru recently joined the World Health Organization, becoming its sixty-seventh member.

Stop-Gap for Headache Pain

Anacin

While the cause of the headache is being determined, the patient can enjoy relief from pain with the aid of Anacin. This dependable APC formula not only gives *fast* relief, but *long-lasting* relief as well, exceeding that of plain aspirin. When your patients need fast, prolonged relief of headache, neuritis or neuralgia pain, why not recommend Anacin tablets? Available at all drug stores and hospital pharmacies.



ANACIN®

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HORMONES

Anaphylactoid Reaction

Both cortisone and ACTH have a strongly inhibiting effect on the anaphylactoid edema caused by the parenteral administration of egg white to rats. Desoxycorticosterone and lyophilized anterior pituitary tend to aggravate the reaction. Dr. Hans Selye of the Université de Montréal, Canada, has found that gluco-corticoids such as cortisone inhibit many of the actions of mineralo-corticoids such as DCA. This observation suggests that adrenalectomy sensitizes the patient to the toxic reactions of DCA by predisposing to an unfavorable gluco-corticoid and mineralo-corticoid balance. Lesions particularly amenable to ACTH or cortisone usually react favorably to nonspecific therapy, fever therapy, and shock therapy. Since these measures stimulate the production of gluco-corticoids, many of the so-called collagen diseases may depend on a derangement of the pituitary-adrenocortical response to stress.

Canad. M. A. J. 61:553-556, 1949.

HORMONES

Rheumatoid Arthritis Therapy

Combined injections of desoxycorticosterone acetate and ascorbic acid have been used in the treatment of rheumatoid arthritis with satisfactory results. Fifteen to thirty minutes after injections, pain almost completely disappeared and mobility improved as much as anatomic joint changes and muscular atrophy would allow for all of 9 patients with slight or severe involvement of two weeks' to fifteen years' duration. Effects last two to six hours, sometimes a day, and are apparently more protracted after each subsequent injection. The pain-relieving effect appears to be confined to the joints. No exact dosages have been worked out, but Drs. E. Lewin and E. Wassén of Sahlgren's Hospital, Gothenburg, Sweden, observe that increasing the dose to more than 5 mg. of DCA with or without 1 gm. of ascorbic acid does not seem to enhance effects, and results are almost equally good with half these amounts. DCA is usually injected intramuscularly and ascorbic acid intravenously two to five minutes later. A delay of as long as two hours between the injections renders the treatment ineffective. No toxic side effects have been observed. Observation time has been two or three weeks.

Lancet 257:993, 1949.

VIRUS DISEASE

Antibiotics for Psittacosis

Life of a chick embryo infected with psittacosis virus can be prolonged by either aureomycin or Chloromycetin, but the latter drug is somewhat less effective. Using equal doses of each antibiotic, Drs. E. Buist Wells and Maxwell Finland of Harvard University, Boston, find that embryos protected with aureomycin live two to three days longer than those given Chloromycetin. Prolongation of life appears to be directly related to dosage for each drug. On a weight basis, aureomycin is more than 3 times as effective as Chloromycetin against psittacosis and more than 5 times as effective on a molecular basis.

Proc. Soc. Exper. Biol. & Med. 72:365-368, 1949.

The Accident-prone Automobile Driver

W. A. TILLMANN, M.D., AND G. E. HOBBS, M.D.*
University of Western Ontario, London, Ont.

A RELATIVELY small group of drivers seems to be responsible for a large number of automobile accidents.*

In a study of high- and low-accident groups among the general driving population and drivers of commercial vehicles, W. A. Tillmann, M.D., and G. E. Hobbs, M.D., find a striking degree of similarity in personalities and backgrounds of the accident-prone drivers. A man's conduct behind the wheel of a car appears to simulate his behavior in other situations.

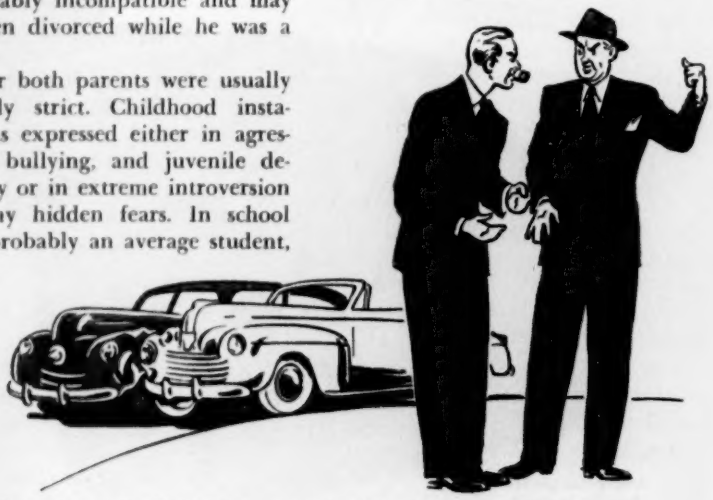
In general, the high-accident driver has a record of instability and resistance to authority. His parents are probably incompatible and may have been divorced while he was a child.

One or both parents were usually excessively strict. Childhood instability was expressed either in agressiveness, bullying, and juvenile delinquency or in extreme introversion and many hidden fears. In school he was probably an average student, but his record was marred by truancy and breeches of discipline.

After the accident-prone driver went to work, he held many different jobs in a short time and was often discharged. If a taxi driver, he probably prefers such work to a more settled routine. As a rule, gambling, dancing, and sports are his principal recreations.

He usually has many acquaintances but few close friends. Sexual promiscuity is common and usually freely admitted and, if married, he evinces little interest in his family. His conversation is frequently interesting but usually compounded of cursing, ob-

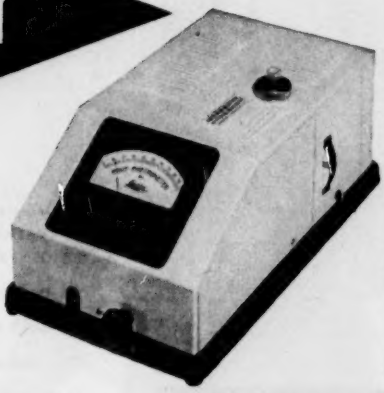
(Continued on page 104)



* The accident-prone automobile driver. Am. J. Psychiat. 106:321-331, 1949.

Now pre-calibrated for 40 common clinical tests including Thymol Turbidity, Red Blood Cell Count

The ROUY Photrometer by Leitz



To make the Photrometer even *more* helpful to busy doctors, Leitz now pre-calibrates for *Thymol Turbidity* and *Red Blood Cell Count* procedures. Since pre-calibration eliminates calculation and the need for preparing standards, the Photrometer simplifies and speeds up **40** of the most commonly required clinical tests.

Unique improvements make the Photrometer the most highly selective and accurate photoelectric colorimeter on the market...accurate to within 0.1%. And it's so amazingly *simple* to operate! There are only two moving parts—a *single control* for all adjustments. An individual handbook accompanies each Photrometer and contains outlines of standard methods which any competent worker can easily follow. With each method there is a calibration table which eliminates any need for calculation.

Here is an invaluable lab assistant that will soon pay for itself in time and money saved. See for yourself what a timesaving aid it can be in a busy practice.

Pre-calibrated for 40 tests—$257.80
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Old model Leitz Colorimeters will be accepted by your Leitz franchised dealer when you buy the new Rouy Photrometer.

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in rheumatic affections...

how can Pabalate provide better salicylate therapy than pure salicylate itself?

THE SUCCESS of salicylate therapy in rheumatic affections has been shown by authoritative reports[3,6] to depend largely on the maintenance of really adequate blood levels . . . frequently a difficult achievement under usual salicylate administration.

Pabalate supplies not only salicylate, but also a "booster" in the form of the antirheumatic para-aminobenzoic acid,[7] which acts to *increase* blood levels of salicylate.[1,2,4,5] In turn, the salicylate increases the blood concentration of the para-aminobenzoic acid.[2] Enteric coating helps Pabalate prevent gastric irritation, insures optimal toleration.

Successful clinical results, contingent on adequate blood levels, can thus be achieved better, more dependably, with Pabalate . . . the "new word for salicylate" in therapy of rheumatic affections.

A. H. ROBINS COMPANY, INC. • RICHMOND 20, VA.
Ethical Pharmaceuticals of Merit since 1878

higher **salicylate blood levels for** better **antirheumatic therapy**

INDICATIONS: *Pabalate Tablets*—for adult patients with rheumatoid arthritis, acute rheumatic fever, fibrositis, gout and osteo-arthritis. *Liquid Pabalate*—for treatment of acute rheumatic fever or other rheumatic diseases in children and as a replacement for tablet salicylate medication; or for adults who prefer a liquid dosage form.

DOSAGE: Average adult dose: two tablets or teaspoonfuls, three or four times daily. Dosage should be adjusted upward if necessary. For children, dosage is proportional to age and severity of condition.

FORMULA: Each enteric-coated tablet or each teaspoonful contains Sodium Salicylate, U.S.P. (5 grs.) 0.3 Gm.; Para-aminobenzoic Acid (as the sodium salt) (5 grs.) 0.3 Gm.

SUPPLIED: Pabalate Tablets in bottles of 100 and 500. Liquid Pabalate in bottles of 1 pint.

REFERENCES:

1. Belisle, M.: Union Med. Canada, 77:392, 1948
2. Dry, T. J. et al.: Proc. Staff Meetings Mayo Clinic, 21:497, 1946
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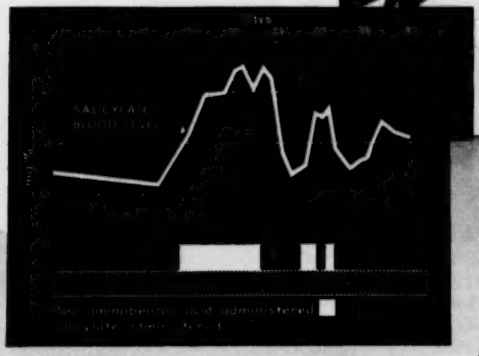
4. Muratore, F. and Pugignone, T.: Bull. Soc. Ital. Biol. Sper., 24:269, 1948
5. Parker, W. A.: Quart. J. Med., 17:229, 1948
6. Reid, J.: Quart. J. Med., 17:139, 1948
7. Rosenblum, H. and Fraser, L. E.: Proc. Soc. Exper. Biol. and Med., 65:178, 1947

Para-aminobenzoic acid increases blood levels of concurrently administered salicylate.[1]



For treatment of rheumatic affections

℞ *Pabalate*

Robins

scenity, and obvious attempts to impress his listeners. Personal dress tends to be eccentric.

His health record shows the common childhood diseases and a number of personal injuries from accidents, but few functional complaints.

On the road his principal concern is to bluff the other driver. He uses the horn a great deal and is particularly angered at finding his own faults in other motorists. Interest in the gadgets and mechanical aspects of the car, but no concern for mechanical limitations is another mark of the accident-prone driver.

Finally, his outlook on life is likely to be fatalistic and materialistic. He lives from day to day with no thought for the future.

The personal history of the driver with few accidents is quite different. His parents were usually congenial and were firm but understanding disciplinarians. As a child he may have been slightly unstable, but not aggressive. His academic standing was average, but disciplinary infractions were few.

This man usually has worked at one job for a long period of time and, if a taxi driver, he would probably prefer employment that offers more security. His interests and recreational activities tend to be conservative, including little drinking and almost no gambling. He has a large circle of friends.

Sexual promiscuity is uncommon and any dereliction is accompanied

simplicity, itself

to prescribe **SIMILAC**

simply add one measure of Similac to two ounces of water to yield two ounces of normal formula of 20 cals/oz

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simply instruct mother to float the prescribed quantity of Similac on previously boiled water and stir

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for { the proteins have been so modified / the fats so altered / the minerals so adjusted

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for term and premature infants throughout the first year of life whenever breast feeding must be supplemented or replaced. Similac has the same zero curd tension as human breast milk.

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by a feeling of guilt. This driver is probably quiet and reserved; he may appear unsociable. His health is probably not as good as that of the accident repeater.

His driving habits are courteous, and he is on the alert for other drivers who may make mistakes. Usually he has no interest in mechanics, is concerned with the welfare of others, and worries a great deal.

In most cases the accident tendency seems to be a fixed trait, but may be reversed by a change in the emotional pattern of the individual. A taxi driver with the background and the personal characteristics of a typical accident-prone individual drove 50,000 miles with 2 serious and 6 minor accidents between the ages of sixteen and twenty-six. After marrying a girl with strong religious inclinations, his behavior changed, and he drove about 550,000 miles in the next twelve years with only 1 minor accident.

Studies have not shown a significant relation between driving skills and accident rate. Safe driving depends more upon judgment and caution than upon mechanical skills. In accident-proneness, the defect is always above, and never below the basal ganglia.

If a personal history were added to driving tests, the accident-prone driver could be discovered even before his driving record unmasks him, and only safe drivers would be licensed.

For the weary old woman of 21

SHE comes to you with marked pallor, complaining of chronic fatigue, no appetite. Her blood picture will probably reveal iron deficiency anemia, and judging by her lack of appetite and general condition you may suspect a concurrent vitamin deficiency. • In such cases, isn't it more convenient and economical to correct both deficiencies with a single preparation? Just three IBEROL tablets, one with each meal, supply 210 mg. elemental iron plus generous amounts of ascorbic acid, vitamin B complex and liver concentrate. Yet, in spite of such potency, IBEROL tablets are compact and easy to swallow. The triple coating makes this possible—Abbott employs the ferrous sulfate itself as one of the coatings, thus reducing bulk and separating the iron from vitamins with which it is not compatible. Abbott

Three Iberol Tablets supply:

FERROUS SULFATE, U.S.P. 1.05 Gm. (representing 210 mg. elemental iron, the active ingredient for the increase of hemoglobin in the treatment of iron-deficiency anemia.)
plus these nutritional constituents:

Thiamine Hydrochloride	6 mg. (6 x MDR*)
Riboflavin	6 mg. (3 x MDR*)
Nicotinamide	30 mg. (2 x RDA†)
Ascorbic Acid	150 mg. (5 x MDR*)
Pyridoxine Hydrochloride	3 mg.
Pantothenic Acid (as Calcium Pantothenate)	6 mg.
Folic Acid	5.1 mg.
Liver Concentrate, N.F.	1.5 Gm.

*Minimum Daily Requirement
†Recommended Daily Dietary Allowance

Iberol® TABLETS

(IRON-VITAMIN B COMPLEX-LIVER CONCENTRATE, ABBOTT)

Without Folic Acid **MACRON* TABLETS**

have the same potent formula as Iberol, but with the folic acid omitted.

*TRADE MARK

Washington Letter

An Expensive Paradox in the Federal Medical Program

The administration's budget for the next fiscal year, now on its way through Congress, brings into clear focus the most costly paradox in the federal medical program.

Medical facilities are being constructed to care for veterans who have non-service connected disabilities, while at the same time administration leaders join nonpartisan critics in condemning expansion of this medical care system.

In this election year, the administration apparently is not demanding change. In his budget message, the President merely skirted this issue. Marshaling arguments against costly benefits, Mr. Truman said:

> I again urge that, in considering new or additional aids for veterans without service disabilities, Congress judge their necessity not merely from the standpoint of military service, but also on the basis of benefits under the general social security, health and education programs available to all people, including veterans. . . . We should provide only for the special and unique needs of veterans arising directly from military service.

However, but a few hundred words farther along in his message, Mr. Truman revealed that Veterans Administration is preparing to handle more, not fewer, cases of non-service connected injuries or illnesses. On this point, the President says:

> Construction of hospitals to provide 37,000 new beds and addition-

"Now this may hurt just a little bit, Doc."

after tonsillectomy...

the chewing of Aspergum, before mealtime, effectively relieves pain, lessens muscle spasm, contributes to patient comfort.

DILLARD'S

aspergum

SALIVARY ANALGESIA

Contains 3½ grains of aspirin in a pleasantly flavored chewing gum base—particularly suitable for administering aspirin to children and to patients who have difficulty swallowing tablets. *Ethically promoted.*

Aspergum is available at all prescription pharmacies in bottles of 36 and 250, packages of 16.

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al domiciliary facilities, costing $872,000,000, is now about one-third completed. By June 1951 it is estimated that three-fourths of the work will have been done. When this program is finished, there will be sufficient beds to provide adequately for foreseeable needs for all service-connected cases *and a more liberal allowance of beds than at present for non-service connected cases.*

There is no suggestion that Congress reexamine the practice of allowing VA to hospitalize veterans for troubles that have no connection with military service.

Immediately following the above quotation, the budget message sets out in round millions of dollars what this service is costing. It states:

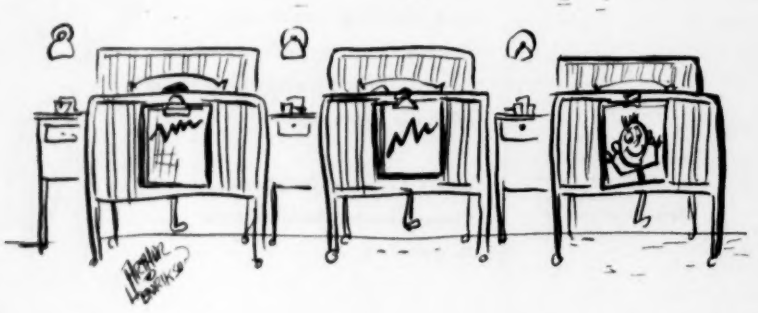
> Current expenses for hospital and medical care are estimated at 590 million dollars in the fiscal year 1951 (starting July 1, 1950). About four-fifths of these expenditures are for the in-patient care program, and in this program two-thirds of the cases currently are non-service connected.

Incidentally, there is an additional cost from this service which VA budget does not reflect. Thousands of veterans with non-service connected disabilities are hospitalized in Army and Navy hospitals. Much of the cost of caring for them appears on the defense budget, not the VA budget. Just what this costs is difficult to estimate, certainly many millions of dollars each year. The total is high enough to cause serious concern among some defense department medical leaders who recently induced Defense Secretary Louis Johnson to issue an order to military hospitals reminding the staff that the primary task was to care for military personnel. However, it is doubtful that this order will affect the present practice.

President and Health Insurance

In none of his communications to Congress so far has Mr. Truman demanded passage this session of his national health insurance program. No one should be misled by the absence of such a demand. Inquiries at the White House clear up any doubt. Mr. Truman is still convinced that nothing but comprehensive, payroll deduction health insurance will provide the nation with adequate medical care. Ultimately, he thinks, Congress and the people will see it this way and legislation along the lines of the Wagner-Murray-Dingell bill will become law.

The impression from the White



with Citrus Fruits and Juices

The rich variety of nutrient factors* in citrus fruits and juices, and their high content of vitamin C and natural fruit sugars,[3] are medically noteworthy — for several reasons: they contribute helpfully to improvement of appetite[4] and digestion,[1] to greater bodily energy[5] and stamina,[3] and to resistance to disease.[2] During pregnancy or lactation, before or after surgery, and for general nutritional support from infancy to old age, the refreshing goodness of low-cost, readily-available Florida-grown fruits and their juices proves universally appealing ... whether in fresh, canned, frozen or concentrated form.

FLORIDA CITRUS COMMISSION
LAKELAND, FLORIDA

*Among the richest known sources of vitamin C are the citrus fruits. They also contain vitamins A, B_1 and P, and readily assimilable natural fruit sugars—together with other factors such as iron, calcium, citrates and citric acid.

References: 1. Gordon, E.S.: Nutritional and Vitamin Therapy in General Practice, Year Book Pub., 3rd ed., 1947. 2. Manchester, V.C.: Food Research, 7:394, 1942. 3. McLester, J.S.: Nutrition and Diet, Saunders, 4th ed., 1944. 4. Rose, M.S.: Rose's Foundation of Nutrition, rev. by MacLeod and Taylor, Macmillan, 4th ed., 1944. 5. Sherman, H.C.: Chemistry of Food and Nutrition, Macmillan, 7th ed., 1948.

FLORIDA
Oranges • Grapefruit
Tangerines

House is that Mr. Truman is not dismayed by lack of interest in his health bill by so many Democrats in Congress. He knows this means delay, but he's convinced it does not mean defeat.

Left Over from Last Session

A number of important health bills were started through the last session of Congress but did not become law. Unless this session becomes tied up in long controversies over taxes, civil rights bills, or foreign aid, several of these health bills have a good chance of passing.

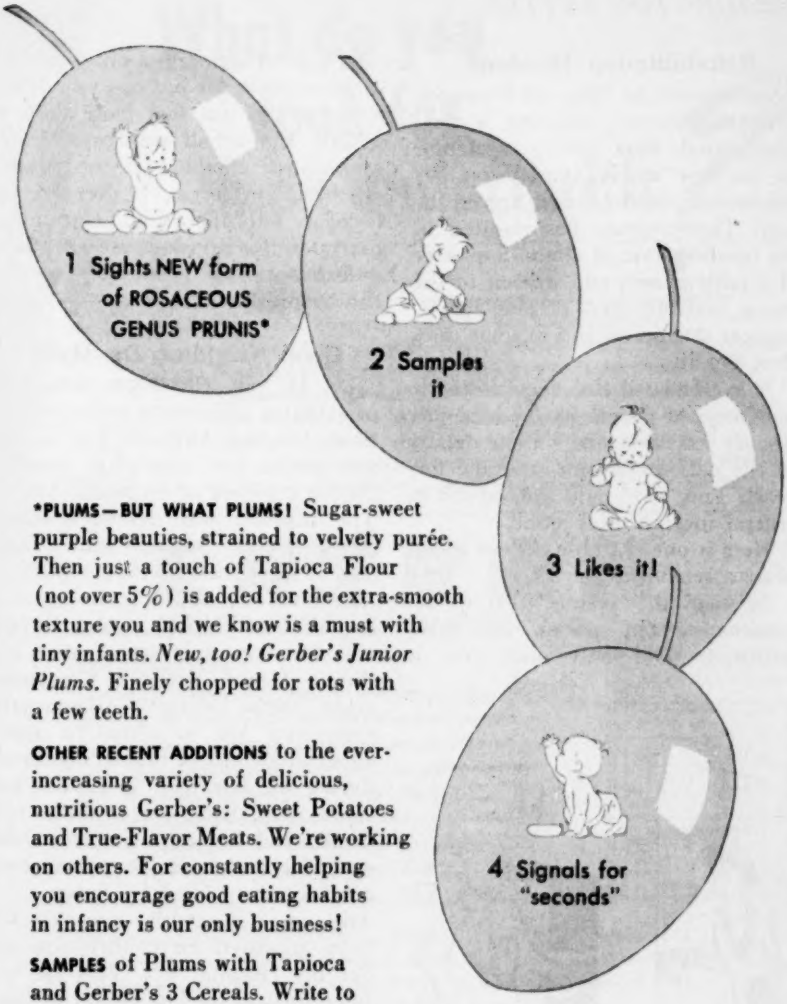
► The school health program, calling for $25,000,000, is almost certain to pass; it nearly became law last session.

► Another bill that has good prospects is one that would increase grants for local public health assistance from $14,000,000 to $23,000,000.

► The bill to help finance medical and related schools also is in high favor in Congress; most of the controversial issues were compromised before end of the last session.

► Creation of a National Science Foundation in the next few months is almost assured; unusual legislative complications were the only reason it was not passed last session.

► If the administration's budget is followed, appropriations for education and general research will be more than trebled, rising from $125,000,000 the current fiscal year to $434,000,000.



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OTHER RECENT ADDITIONS to the ever-increasing variety of delicious, nutritious Gerber's: Sweet Potatoes and True-Flavor Meats. We're working on others. For constantly helping you encourage good eating habits in infancy is our only business!

SAMPLES of Plums with Tapioca and Gerber's 3 Cereals. Write to Dept. 213-0, Fremont, Mich.

Gerber's

BABY FOODS

Fremont, Mich.

Babies are our business... our only business!

Rehabilitation Dividend

Statistics of the Office of Vocational Rehabilitation, covering a five-year period, show that as a nation we are not wasting money on the $76,000,000 rehabilitation appropriation. The program has resulted in the rehabilitation of almost a quarter of a million men and women to the extent that they have become able to support themselves and in some cases their families.

It is calculated that these formerly handicapped people have added just slightly less than one billion dollars to the nation's income over the five years. They have paid $70,000,000 in federal income taxes alone.

Here is one example of how federal-state rehabilitation works:

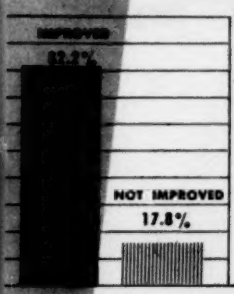
In 1948 the average cost of rehabilitating one person was $460, which is paid only once. Yet it costs $492 to maintain a blind person in dependency for just one year. The report points out that more than a million and a half persons still are so seriously disabled as to require rehabilitation service if they are to become self-supporting. Currently, federal and state funds are adequate to care for only 1 out of 5 of the handicapped.

"Don't be alarmed. I've just had a little trouble with the plumbing."

Good Neighbor, Dr. Hyde

Dr. H. van Zile Hyde, who has contributed ability and energy to the World Health Organization, is the new health and sanitation director for the Institute of American Affairs. The Institute was created to carry on cooperative programs among fourteen of the Latin American republics. In another capacity, it is the regional organization through which WHO will function in these areas. . . . Public Health Service's Communicable Disease Center at Atlanta gave emergency aid to seventeen states where epidemics or disasters occurred during the last year. It assisted five states that had poliomyelitis epidemics and five others in which encephalitis broke out. The other emergencies were caused by floods. . . . The one-thousandth hospital has been approved for construction under the Hospital Act. This act was liberalized in the last session of Congress and offers greater opportunity to small towns and low-income communities. . . . Public Health Service will continue its influenza information center. This office, set up a year ago, is western hemisphere headquarters for a world-wide campaign for research into and control of this disease.

What do you look for in an antiarthritic ?



EFFECTIVENESS?

With Ertron,® local and systemic improvement has been reported in 701 out of 852 arthritic patients. Thus beneficial results were obtained in 82%; and no improvement was noted in only 17.8%. In a disease as resistant as rheumatoid arthritis, this is truly effective therapy.[1]

"No specificity is claimed for Ertron therapy. However, any substance which is non-toxic and which by its general systemic action does produce improved sense of well-being, diminution of soft tissue swelling, relief of pain, and improved muscle strength and which does make possible a return to gainful occupation, should be used in the treatment of arthritic patients."[2]

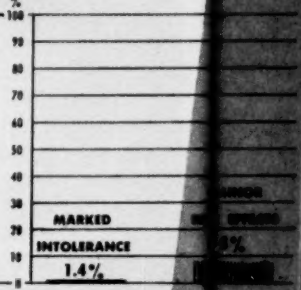
ERTRON

STEROID COMPLEX, WHITTIER

TOLERABILITY?

Tolerance to Ertron is high in patients under periodic observation. Untoward side reactions are rare.[3] In 1,020 arthritic patients, marked intolerance requiring cessation of therapy occurred in only 1.4%, while minor side effects, such as nausea, gastrointestinal upset, headache, etc., were encountered in about 8%.

"These mild digestive disturbances disappear almost immediately after the cessation of Ertron administration and usually do not recur when this therapy is again instituted."[4]



Ertron is supplied in bottles of 50, 100 and 500 capsules, and Ertron Parenteral in packages of six 1 cc. ampuls. Each capsule contains 5 milligrams of activation-products having antirachitic activity of fifty thousand U.S.P. units. Each ampul contains activation-products having antirachitic activity of five hundred thousand U.S.P. units, in sesame oil. Biologically standardized.

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Whittier

LABORATORIES • DIVISION NUTRITION RESEARCH LABORATORIES, CHICAGO 30, ILLINOIS

What Would You Say?

Twice a month we will select a caption for this cartoon from those sent in by our readers and send the author $5. This caption was written by

Calvin B. Kitchen, M.D.
Cleveland

Mail your caption to The Cartoon Editor, MODERN MEDICINE, 84 South 10th St., Minneapolis 3, Minn.

"Well, you know you can deduct the full amount from your income tax."

the fluid sulfadiazine that's

. . . better tasting

. . . faster acting

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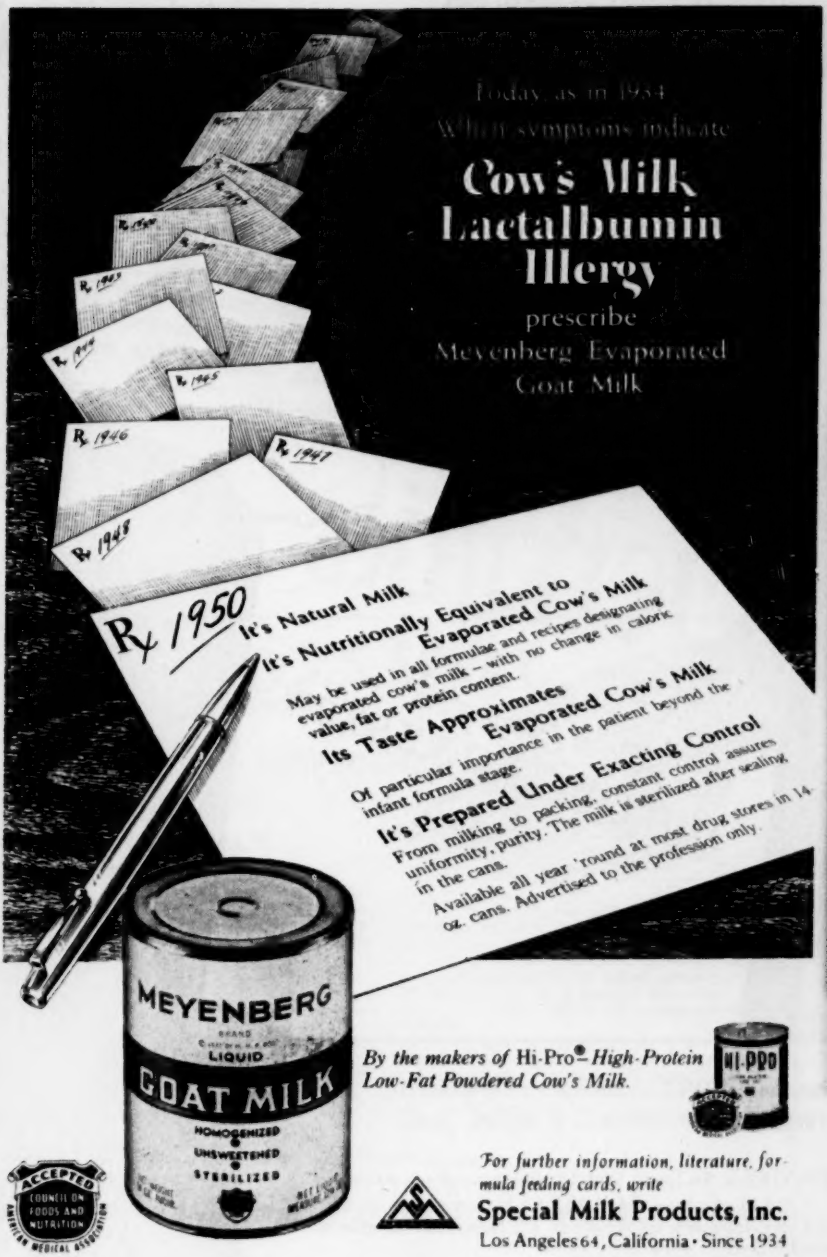
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The Full Circle

I was once a patient at a famous clinic. I was so grateful for all they did for me that I felt I owed the head physician something more than his fee, so I sent him an expensive engraved fountain pen for Christmas.

A year or so later I was passing through his town, so stopped in his office just to say "Hello." While there I had occasion to sign some papers and found that there was no ink in my pen. The famous surgeon handed me his. It was the pen I had sent to him. I was proud to think that he still cherished and used it.

As I screwed the cap back on and started to hand it back, he said, "You might need it later. Just take it along with you. I've got a whole drawer full that I'll never use. Patients have sent them to me as presents. That's one I haven't used."

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"I never realized these shots would be such a pain in the er-ah-ahem . . ."

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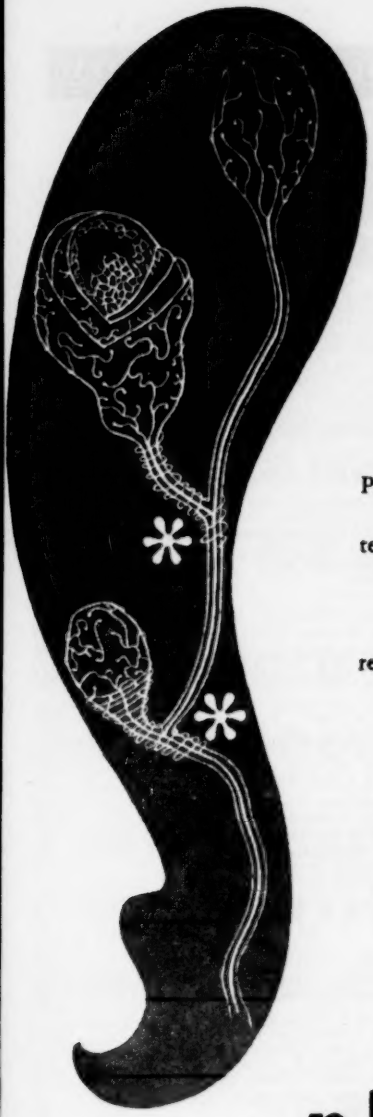
The following incident occurred in my practice recently.

The woman's voice on the country telephone sounded faint as she asked what to do for her father, who was constipated. It was impossible to carry on a conversation because the line kept fading, and our voices would cease to be heard. My last words to her were "Give him an enema," and then I futilely hung up, afraid that the woman had not heard my directions.

A few minutes later, the phone rang again. I couldn't distinguish what the woman was saying, but I was taking no chances this time. I shouted, "Give him an enema." Imagine my dismay when the voice, now suddenly clear and obviously that of another woman, reported acidly, "That's the first time I was told to give an enema for an ingrown toenail!"—A.G.



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Abbott Laboratories 107
American Cystoscope Makers, Inc. 99
American Ferment Company, Inc. 79
American Sterilizer Company 26
Angier Chemical Co. 126
Ar-Ex Cosmetics, Inc. 126
Arlington Chemical Company, The 36-37

Barnes, A. C., Company 11
Bauer & Black 81
Belmont Laboratories 30
Birtcher Corporation, The 40
Borden Company, The 66-67
Burroughs Wellcome & Co. (U. S. A.) 125

Central Pharmacal Co., The 83
Chatham Pharmaceuticals, Inc. 27
Chicago Dietetic Supply House, Inc. 124
Chilcott Labs. Div. of Maltine Co. 5
Ciba Pharmaceutical Products, Inc. ..... 23, 4th Cover
Creditors Association 122

Dome Chemicals, Inc. 128
Drug Specialties, Inc. 126
Durst, S. F., & Co., Inc. 127

Eaton Laboratories, Inc. 75
Everest & Jennings 122

Florida Citrus Commission 111

Gebauer Chemical Company, The 121
Gerber Products Co. 113
Geriatrics 129
Graham-Field 122

Hoffman-La Roche, Inc. 8

Increto Products Corp. 128
Johnson & Johnson 86-87

Knox Gelatine 78
Kremers-Urban Company 92-93

Lederle Laboratories, Inc. 33
Leitz, E., Inc. 101

McNeil Laboratories, Inc. 3
Merck & Co., Inc. 19
Merrell, The Wm. S., Company ..... 2nd Cover
M & R Dietetic Laboratories, Inc. 105

National Drug Company, The 29, 130
National Synthetics, Inc. 77
New York Pharmaceutical Company 124

Petra Manufacturing Co. 112
Professional Drugs, Inc. 4
Professional Printing Company, Inc. 31

Robins, A. H., Company, Inc. 15, 85, 102-103
Roerig, J. B., & Company 89
Rystan Co., Inc. 43

Schenley Laboratories, Inc. 21
Schieffelin & Co. 107
Seeck & Kade, Inc. 35
Shampaine Company 116
Sharp & Dohme 12-13
Sherman Laboratories 95
Shield Laboratories 22-23
Smith, Kline & French Laboratories 7, 34, 91, 117
Smith, Martin H., Company 123
Special Milk Products, Inc. 119

Tailby-Nason Company 118
Toidey Company, The 128

Ulmer Laboratories 129
U. S. Vitamin Corporation 41

Vaisey-Bristol Shoe Co., Inc. 32
Varick Pharmacal Co., Inc. 104
Viobin Laboratories 39

Walker Vitamin Products, Inc. 17
Wampole, Henry K., & Co., Inc. 42
White Laboratories, Inc. 18, 109
Whitehall Pharmacal Company 97
Whittier Laboratories 115
Wilco Laboratories 124
Winthrop-Stearns, Inc. ..... 3rd Cover
Wyeth Incorporated 44

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